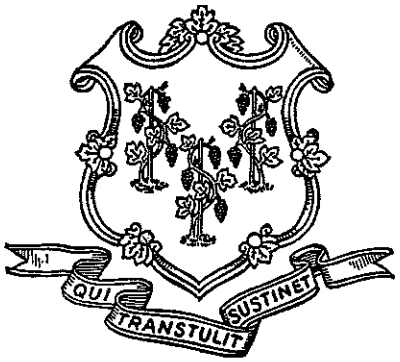
WORKERS' COMPENSATION: IMPACT OF THE 1991 AND 1993 REFORMS

Connecticut

General Assembly



LEGISLATIVE
PROGRAM REVIEW
AND
INVESTIGATIONS
COMMITTEE

December 1995

CONNECTICUT GENERAL ASSEMBLY
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

The Legislative Program Review and Investigations Committee is a joint, bipartisan, statutory committee of the Connecticut General Assembly. It was established in 1972 to evaluate the efficiency, effectiveness, and statutory compliance of selected state agencies and programs, recommending remedies where needed. In 1975, the General Assembly expanded the committee's function to include investigations, and during the 1977 session added responsibility for "sunset" (automatic program termination) performance reviews. The committee was given authority to raise and report bills in 1985.

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LEGISLATIVE PROGRAM REVIEW AND
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EXECUTIVE SUMMARY

The Legislative Program Review and Investigations Committee authorized a study of the state's workers' compensation system in February of 1995. The purpose of the study was to analyze the effects on the system of two major reform acts passed in the previous five years (P.A. 91-339 and P.A. 93-228). The acts were intended to improve the system's administration and reduce workers' compensation costs for the state's employers.

The study examines the extent to which the requirements of the legislation have been implemented and the impact of the changes on the system. Attention is focused on compliance with the statutory mandates by the Workers' Compensation Commission, the state agency charged with administering the system, and the impact the structural and benefit reforms had on workers, employers, and insurers.

The committee developed findings in the areas of: the commission's administration and financing; the enforcement of insurance coverage requirements; filing of injury reports; and development of workplace safety committees. The committee also arrived at conclusions concerning: workers' compensation insurance rates and the profitability of that line in Connecticut; the reclassification of employers for insurance rating purposes; and the trend in benefit costs.

Compliance

Administration. The committee found that the centralization of administrative responsibility and authority in the office of the commission's chairman, required by the 1991 and 1993 reform acts, has been accomplished. However, the committee concluded that the micro-management approach practiced by the commission's central office, while necessary for the initial implementation of the administrative changes, is no longer needed and its continuation is beginning to produce a negative attitude among staff.

Financing the commission. The committee found that the Workers' Compensation Commission has consistently and substantially overstated its budget needs during the past four years. As a result, the commission has accumulated a $21 million surplus by assessing businesses at artificially high levels.

Productivity and efficiency. The committee found that, despite improvements in the administration of the commission, advances in productivity and cost efficiency were mixed. Measures of productivity and cost efficiency associated with processing workers' compensation claims exhibited improvement, while the same measures applied to the disposing of claims showed signs of deterioration.

Enforcement concerning coverage. Protection against workers' compensation liability is statutorily required of virtually all employers. There are several statutes that provide for the enforcement of the coverage requirements, but the problem the committee found was that historically the enforcement of these statutes has been weak and the responsibilities of the multiple state agencies involved were poorly defined.

First injury report. The Workers' Compensation Commission is responsible for compiling statistics concerning occupational injuries and diseases. The committee found indications that workplace accidents were somewhat underreported to the commission. Accident data collected by the Connecticut Department of Labor, (Division of Occupational Safety and Health) were, with the exception of 1992, consistently and substantially higher than those lost-time injuries reported to the commission. The statistics are important for planning purposes and for fully implementing the mandates concerning worker health and safety committees. The committee concluded that one problem with getting compliance is that, while sanctions can be imposed on employees if they do not report accidents, no such disincentives exist for employers.

Workplace safety committees. Both the 1991 and 1993 reform acts addressed workplace safety committees. Yet, almost two years lapsed before the regulations necessary to implement the legislation finally took effect in May 1995. The committee found that the regulations adopted do not provide much guidance or clarity of the statute, and in fact, dilute the role of the health and safety committees in describing their duties.

The program review committee did find, however, that the two-year lag in regulation development was justified, given that a legal interpretation was sought concerning whether the proposed regulations posed a conflict with federal requirements. The committee concluded that the regulations do promote a cooperative approach to health and safety in the workplace that appears to be well-received by both business and labor, and has been shown in the literature to be a potentially effective way to reduce illnesses and injuries. It is still too early to evaluate whether this approach will be effective in Connecticut, as the monitoring of the establishment of these committees has just begun.

Impact of Reforms

Insurance rates. The committee's analysis indicates that Connecticut's rate experience in workers' compensation insurance has been improving, and that its rates appear to be becoming more competitive with other states. However, the committee became concerned that in setting rates, rating organizations may be overly cautious in estimating any reductions that might occur from systemic or law changes, while stretching the predicted increases in rates from other changes. The committee concluded -- based on results of managed care cost reductions in other states like Florida, and early indications of cost decreases here in Connecticut -- that employers with managed care plans must be assured that cost decreases are translated into reduced rates for them.

Reclassifications. A factor closely related to rates is how a business is classified for rating purposes. Several parties expressed a concern that insurers used reclassification as a means to maintain high premiums. The committee found that reclassification upward was not widespread, that the classifications used to describe work activity are used nationwide and are not unique to Connecticut, and if an employer is unhappy with the classification or reclassification, there is a mechanism for appeals. Further, the appeals are decided in favor of the employer almost as often as against. Thus, the committee concluded there is no need for a recommendation in this area.

Profitability. The committee found that the aggregate profit level for companies that write workers' compensation insurance in Connecticut has been higher than most other states and the national average. Connecticut averaged 11.7 percent over the last 7 years, while nationwide the average was 7 percent. The committee concluded that while Connecticut's past profit levels were reasonable, the 1993 (19.0 percent) and 1994 (32.4 percent) levels appear excessive. Although the phenomenon of high profit levels following a period of reform is not unique to Connecticut, the committee did recognize that such profit levels cannot be tolerated for long. It considered three options: 1) a state competitive fund; 2) a consumer rate counsel or ombudsmen connected with the state Insurance Department; and 3) lowering the criteria the Insurance Department uses for group self-insurers in order to foster expansion of group self-insurance. After noting significant drawbacks to the first two options, the committee adopted the third as its proposal.

Benefit costs. The committee found that, after rising significantly from the mid-1980s through 1991, the monetary value of the benefits paid under the state's workers' compensation laws leveled off for a couple of years and then dropped slightly in 1994. An analysis of data provided by the National Council on Compensation Insurance indicated that the cost of the indemnity benefits paid to injured workers -- currently estimated to be 47 percent of total benefit costs paid by private insurers -- has been declining in recent years, while the cost of medical benefits -- 53 percent of total benefit payments in the private insurance market -- has been rising. Great caution is required in this area since these data reflect the experience of the private insurance market and exclude the experience of companies that self-insure, which in 1994 accounted for 21 percent of all benefit costs.

RECOMMENDATIONS

Administration of the Commission

1. The Workers' Compensation Commission should prepare a policy statement for review and approval by the advisory board that outlines a role for commissioners and district office administrators in the development of administrative policies and procedures.

2. The Workers' Compensation Commission should develop an in-service training module that requires all central office managers to spend a specified period of time observing first hand and performing the tasks that are part of the routine functioning of a district.

3. The Workers' Compensation Advisory Board must vigorously assert its authority and fulfill its responsibility to review and help shape the policies governing the administration of the workers' compensation system.

Financing the Commission

4. Reserves in the Workers' Compensation Administration Fund determined by the state comptroller to be in excess of $5,000,000 shall be used to reduce the annual assessment on employers to finance the operations of the Workers' Compensation Commission.

Operations

5. The Workers' Compensation Commission should assess its current allocation of personnel and put greater emphasis on placing staff in positions directly involved in processing claims and rendering decisions.

6. The Workers' Compensation Commission should assess its role in the decline in the use of voluntary agreements to dispose of claims and together with its advisory board develop policies that will encourage workers and employers to make greater use of this alternative.

Case Appeals

7. The chairman of the Workers' Compensation Commission should examine ways for the appeals board to expedite the processing of appeals such as:

    - ♦ allotting additional time for the board to meet and hear appeals;
    - ♦ establishing clear policies concerning the criteria for which a petition for appeal will be accepted, and communicating those policies to commissioners, staff, insurance companies, and the claimants' and respondents' bar; and
    - ♦ requiring Compensation Review Board support staff to screen the petitions for appeals to ensure they meet the criteria established before being set down for board review.

Rates and Competitiveness

8. The Connecticut Insurance Department should adopt the National Association of Insurance Commissioners model regulations for Private Employer Workers' Compensation Group Self-Insurance Model Act. Further, the program review committee recommends that monetary criteria for approval be set at the same limits as contained in the model regulations.

Insurance Coverage Enforcement

9. C.G.S. Section 31-288(e) shall be amended to state that "Whenever a Workers' Compensation Commissioner imposes a civil penalty under Section 31-288 (c) or (d), the order shall indicate that payment is to be made to the Second Injury Fund of the Office of the State Treasurer, and that failure to pay within 90 days may result in civil action and double the penalties. The chairman of the Workers' Compensation Commission shall notify both the Office of the State Treasurer and the Office of the Attorney General of the imposition of the penalty, the date it was imposed, the amount, and if such penalty is appealed. The state treasurer shall collect any penalties owed and shall notify the chairman of the Workers' Compensation Commission and the Attorney General's office if the penalty is not paid within the 90-day period so that civil action pursuant to Section 31-289 may be brought."

10. Section 31-289b should be changed to state that the attorney general may bring civil action against any employer who knowingly fails to comply with any aspect of the workers compensation statutes, rather than the current language of "wilfully and repeatedly" fails to comply.

Medical Reforms

11. The Workers' Compensation Commission and the Insurance Department should review the results of medical cost and utilization data as they become available to ensure that employers are capturing the benefits of any medical cost savings in their workers' compensation insurance rates.

12. The Workers' Compensation Commission should develop an oversight capability to monitor how insurers and/or employers are disseminating information about their managed care plans. The goal should be that workers know:

- what their rights and responsibilities are for seeking medical treatment, both initial and referral to specialists, under workers' compensation managed care;
- who the current providers are under their employer's managed care plan; and
- how to proceed if he or she has a question, concern, or complaint about medical treatment provided.

13. Statutorily require that the workers' compensation rating organization and insurance companies develop and submit separate workers' compensation rates for employers who have approved managed care plans in place to provide medical care for injured workers and employers who do not.

Health and Safety Committees

14. The program review committee recommends the following:

- the regulations as promulgated continue to serve as the guidelines for implementation of the health and safety committees in the workplace;
- the Legislative Program Review and Investigations Committee, in cooperation with the Labor and Public Employees Committee, review the results of these committees at the end of calendar year 1998 to evaluate whether the committees, as constructed and authorized under the current regulations, should be rewritten to be more in line with the legislation contained in P.A. 93-228; and
- the criteria used in the review should include, but not be limited to: employer compliance with the health and safety committee requirements; business and labor opinion; and impact of committees in reducing work-related injuries.

15. The Workers' Compensation Commission's current monitoring efforts should first concentrate on those employers with more than 25 employees but with worse than average safety records.

Filing of First Injury Reports

16. Section 31-316 of the Connecticut General Statutes should be modified to indicate that if an employer fails to report the notices of injuries as required, the workers' compensation commissioner, upon a determination that the employer did not file the report, may increase the award for compensation to the injured employee proportionately to the prejudice that the employee sustained by reason of the employer's failure to file.

17. Staff in the WCC assigned to educate employers and employees about workers compensation should bolster efforts to educate employers of the statutory requirements to file the first reports of injury with the Workers' Compensation Commission. The forms themselves should be modified to include when, how, and to whom the form should be filed.

INTRODUCTION

The Legislative Program Review and Investigations Committee (LPR&IC) authorized a study of the state's workers' compensation system in February of 1995. The purpose of the study was to analyze the effects on the system of two major reform acts passed in the previous five years. The bills, Public Acts 91-339 and 93-228, were intended to both alter the way the system was administered and reduce workers' compensation costs for the state's employers.

Scope

The study examined the extent to which the requirements of the legislation had been implemented and the impact of the changes on the system. Attention was focused on compliance with the statutory requirements by the Workers' Compensation Commission (WCC), the state agency charged with administering the system, and analyzing the impact the structural and benefit reforms had on workers, employers, and insurers.

Methodology

Information was obtained through a variety of sources and means. Data and procedural descriptions were acquired from standard state agency documents and reports, as well as national associations and research groups. Committee staff conducted extensive interviews of staff from the Workers' Compensation Commission, labor leaders, attorneys, medical providers, and economists. The staff also met with representatives of several insurance companies in a forum arranged by an industry trade association, and held meetings with three separate groups of private employers in forums arranged by local chambers of commerce.

Data related to the processing and outcome of individual claims were obtained from a sample of 175 cases heard by the Workers' Compensation Commission. Opinion data were gathered through mailed surveys of 21 commissioners and staff of the commission and more than 400 employers and 450 labor leaders.

A staff briefing for the program review committee was held in August 1995. During the briefing, the committee was provided descriptive information and the results of some preliminary staff analysis of the implementation and impacts of the legislative reforms. In September 1995, the committee held a public hearing on the topic. Finally, a set of draft findings and recommendations were discussed and adopted by the committee in December 1995.

Organization of the Report

The report is organized into eight chapters and four appendices. The opening chapter provides a brief description of the conditions that brought about the initial legislative reforms and

gives an overview of the operation of the state's workers' compensation system. Chapters II through VIII are centered around individual topics. Typically, these chapters provide a limited amount of background information followed by an analysis of the issues involved and the committee's findings, conclusions, and recommendations. Appendix A contains the response of the Workers' Compensation Commission to the report. The remaining appendices provide the tabulated responses of the surveys returned by the commissioner and staff of the commission, employers, and labor leaders.

CHAPTER I

BACKGROUND

Under Connecticut's workers' compensation system a person who suffers an occupational injury or illness is provided wage replacement and medical benefits. The system is based on a no-fault concept, meaning that as long as the injury or illness is work-related the employee is entitled to benefits regardless of fault. In return for being required to provide compensation, the employer cannot be sued by the employee because of the occupational injury or illness.

The Workers' Compensation Commission is the state agency established to administer Connecticut's compensation laws. Among the commission's administrative responsibilities are: receiving reports of work-related injuries and illnesses; approving settlements between employees and employers; resolving disputes between employees and employers or their insurers; and approving requests from employers to self-insure.

Employers are required under C.G.S. Sec. 31-316 to report all employee injuries to the commission. Figure I-1 shows the number of such reports received by the commission over the last 10 state fiscal years. It should be noted that not all of the reported accidents result in a workers' compensation claim, and a majority of those that do are settled by workers and employers or their insurers with little involvement of the commission. However, the reports are a good indicator of the commission's workload, and the rise shown in Figure I-1 was matched by an increase in the volume of cases brought before the commission.

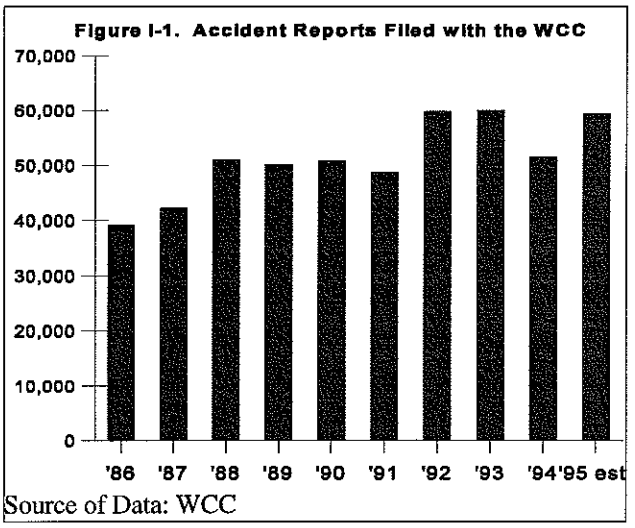
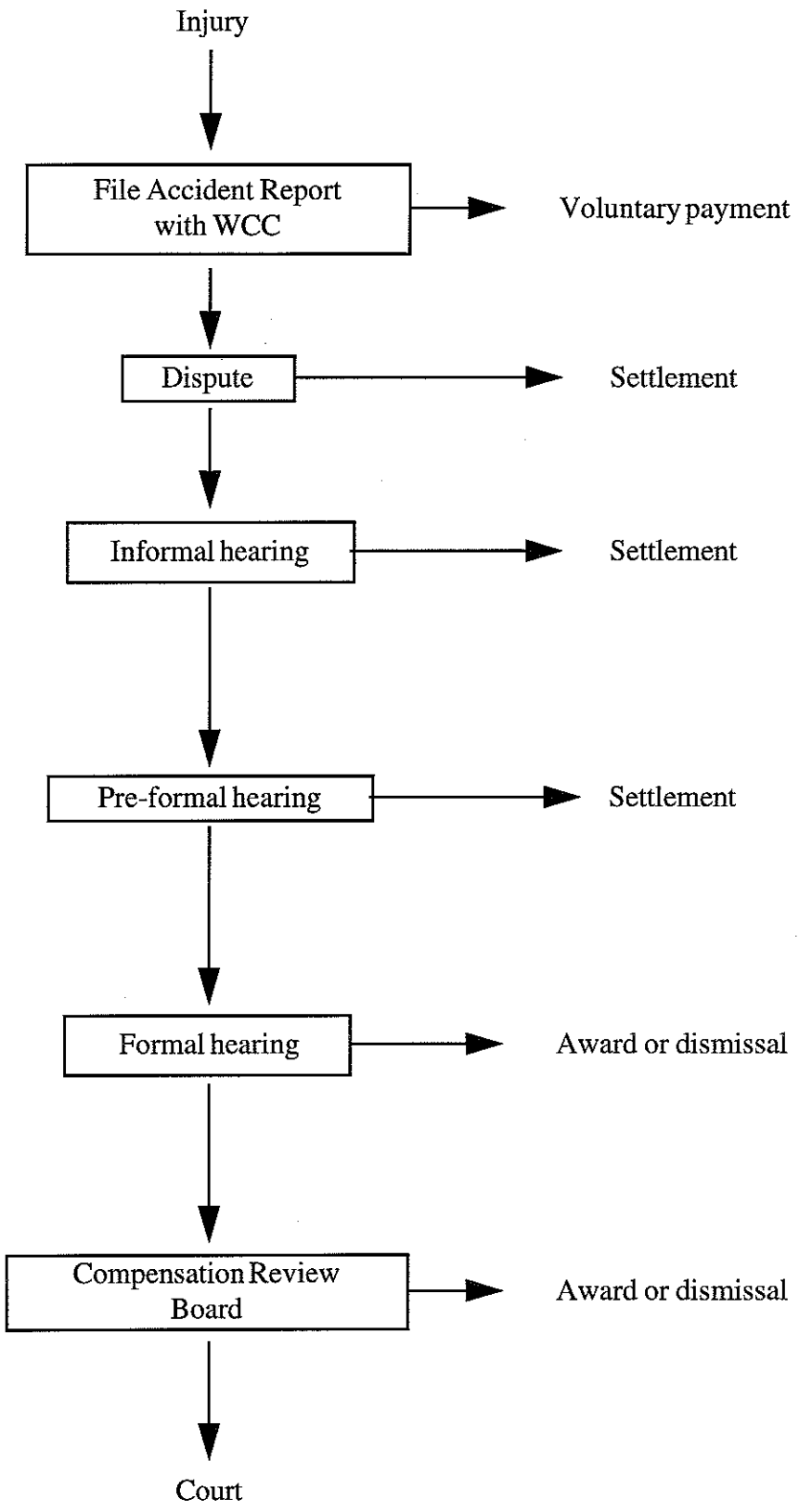


Figure I-2 depicts the commission's basic process for handling claims. It shows that cases involving voluntary agreements between the parties, about 80 percent of the commission's dispositions between FY 85 and FY 94, move through the system with only minimal demands on the commission's resources. As Figure I-2 illustrates, most of the commission's case-handling procedures are geared toward resolving disputes that may arise at any point in the process and concern a wide range of issues such as the compensability of the injury or illness, the extent of disability, the employee's ability to return to work, or the timely payment of benefits.

When the parties are unable to reach an agreement on their own a workers' compensation commissioner attempts to mediate. The commissioner's first step in the process is to convene an informal hearing. If the commission's informal efforts fail to resolve the dispute, formal proceedings

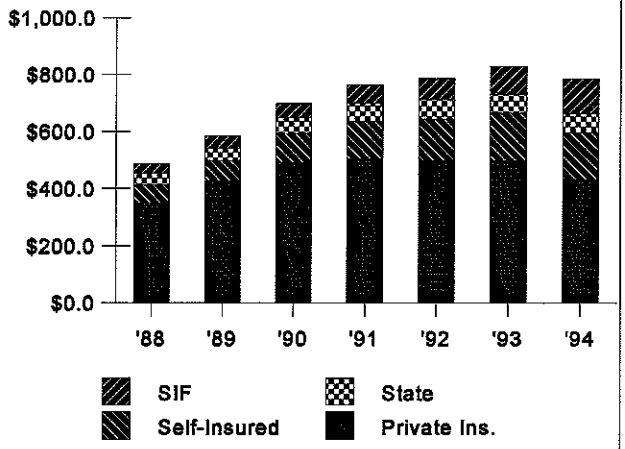
FIGURE I-2. BASIC WORKERS' COMPENSATION CLAIM PROCESS



are initiated. At the conclusion of the formal proceedings the commissioner issues findings and orders. Decisions of the commissioner may be appealed to the commission's Compensation Review Board and then to the courts.

The increase in reported accidents that began in the mid-1980s was accompanied by a rise in the value of benefits paid to claimants. This is shown in Figure I-3, which graphs the value of the compensation paid to workers by the source of the payer (Second Injury Fund -- SIF, self-insured employers, privately insured employers, and the State of Connecticut). Benefits costs peaked at approximately $800 million in 1993. The significance of the shifts in the amount and portion of total benefits paid by the parties identified in Figure I-3 will be discussed later in the report.

Figure I-3. Value of Compensation Benefits Paid (In 000,000s)



Source of Data: WCC and the Second Injury Fund

By the late 1980s, the rapid rise in reported accidents and the cost of providing benefits began to affect how the state's workers' compensation system was viewed by claimants, employers, and public policymakers. There was growing dissatisfaction among all parties with the commission's administration of the system. In addition, many employers began to demand that something be done to stem the rising cost of benefits.

In 1990, at the request of legislative leaders the program review committee undertook a study of the system. The committee's findings and recommendations contributed to major legislative changes enacted by the 1991 session of the General Assembly. The legislation, Public Act 91-339, overhauled the administration of the system and significantly altered its benefit structure. Two years later, the General Assembly through Public Act 93-228 made further reductions in benefits and additional refinements in the administration of system.

CHAPTER II

ADMINISTRATION

Background

Prior to the passage of Public Act 91-339, the organizational structure of the Workers' Compensation Commission included a board of commissioners; the chairman's office; eight district offices; and divisions for appeals, education, and rehabilitation. The board was made up of the commission chairman, the eight commissioners who headed the district offices, and the four at-large commissioners. The board was responsible for setting commission policy. The commission's statewide administrative functions were under the control of the chairman, and the units responsible for these operations were part of his office. The chairman also served as head of the commission's appeals division, which consisted of the chairman and two commissioners chosen by the him to serve on a rotating basis.

The district offices were responsible for processing claims and mediating and adjudicating disputes between employees and employers or their insurers. Each office operated under the direction of a commissioner who was appointed as the administrative and adjudicative head of the office. The district offices received policy guidance from the board and administrative support from the chairman's office.

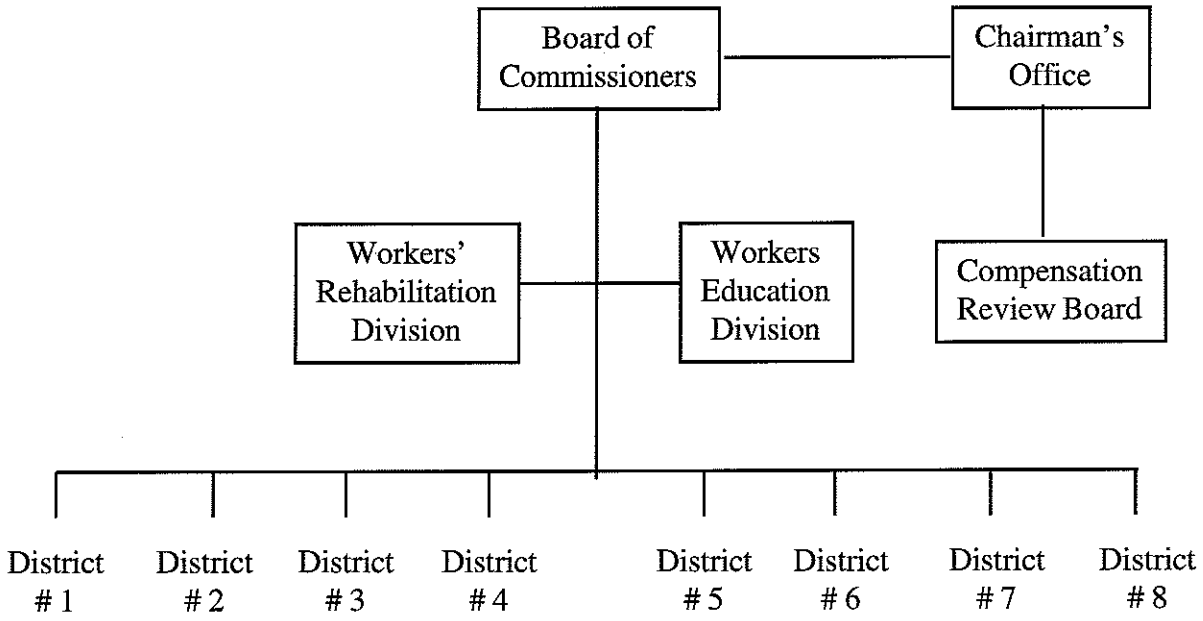
The education and rehabilitation divisions were mandated by state law and funded directly under statutory formulas that assessed employers. Each division was led by a director who reported to the board. As with the district offices, the divisions dealt with the board on policy matters and were provided administrative support by the chairman's office.

A comprehensive study of the state's workers' compensation system conducted in 1990 by the program review committee found that the commission was not responsive to either employees or employers, its management was weak, and accountability was lacking. The study revealed the existence of considerable variation in the policies, procedures, and operating efficiency of the eight district offices. In addition to the administrative shortcomings, the committee found that the commission had inadequate resources to deal with its rapidly expanding workload. The findings concerning the administration of the commission went largely uncontested by the commission, business, labor, and other interested parties in various forums held after the release of the committee's report in January 1991.

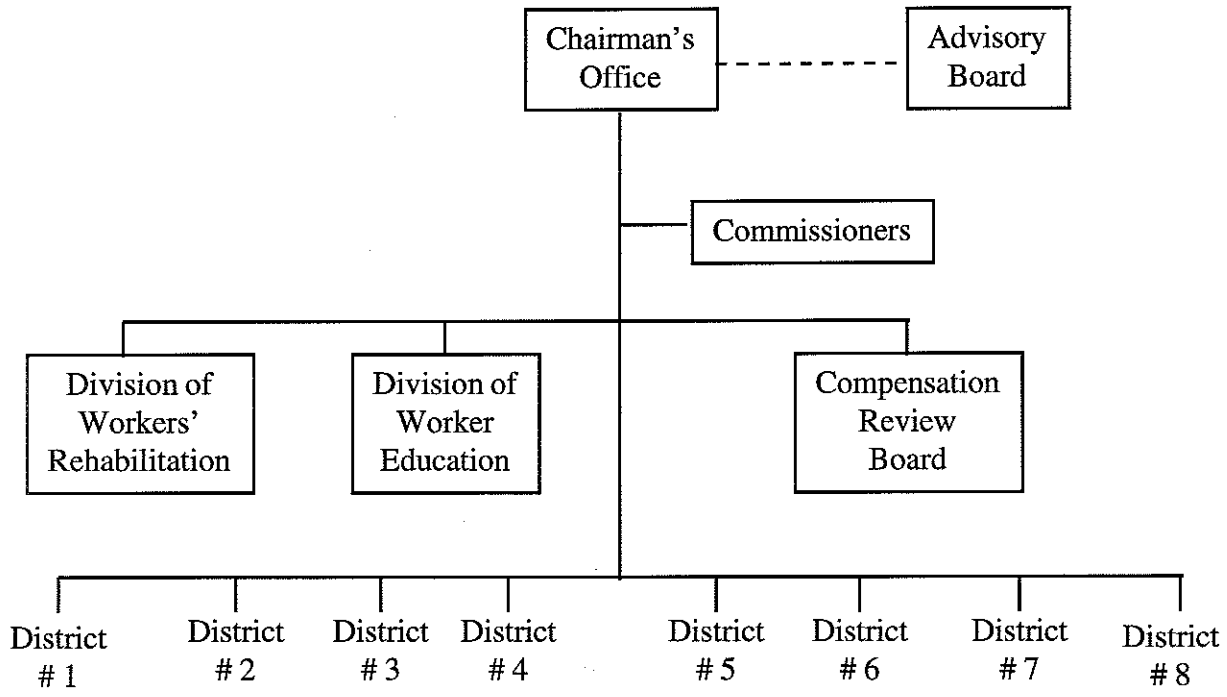
Many of the administrative changes recommended by the committee were adopted as part of Public Act 91-339. The organizational changes can be seen in Figure II-1, which compares the commission's structure before and after passage of the 1991 act. Noteworthy among the changes illustrated are the: elimination of the Board of Commissioners; creation of an advisory board; and placement of the district offices and the divisions of education and rehabilitation under the control the chairman.

FIGURE II-1. WCC Organizational Structure

Prior to 1991 Reform



Current Organizational Structure



Centralization of Responsibility and Authority

Beyond the structural changes, P.A. 91-339 caused a fundamental shift in the distribution of power within the commission by significantly expanding the responsibility and authority of the chairman's position and greatly reducing that of the other commissioners. The changes highlighted in Table II-2 show the chairman's administrative responsibility and authority increased, while the independence of the commissioners and division directors was diminished.

TABLE II-2. Key Changes in Responsibility and Authority

PRE P.A. 91-339	POST P.A. 91-339
***Board of Commissioners*:** The 13 commissioners acting collectively through the board set commission policy.	The board was eliminated, and its authority to set commission policy was transferred to the chairman.
***Chairman*:** The chairman was the administrative head of the commission. He managed the budget, assigned the at-large commissioners, appointed temporary commissioners, kept records pertaining to the entire system, and issued required reports. The chairman also served as head of the compensation review division and had the power to hear claims.	Significant powers transferred to the chairman included the authority to: - adopt rules & propose regulations - prepare & adopt an annual budget & operating plan - direct administrative staff - establish standards and fees governing matters involving the provision of medical and legal services - approve self-insurance requests from employers Significant new powers given to the chairman included the authority to: - establish districts & assign commissioners & staff - establish an organizational structure & allocate resources - appoint division directors & oversee their activities - establish employment procedures and training programs for staff - establish a uniform case processing system and develop guidelines to expedite cases - approve employer-sponsored medical plans
***Compensation Review Division*:** A statutorily mandated division charged with hearing appeals of commissioner's decisions. The hearings were held by three-member panels composed of the chairman and two commissioners chosen by him to serve on a rotating basis.	The division's name was changed to Compensation Review Board. Its reporting lines were changed from the board to the chairman's office.

PRE P.A. 91-339	POST P.A. 91-339
Worker Education Division: A statutorily mandated division charged with informing workers and employers of their rights and responsibilities under the law and aiding them in improving workplace safety. The division was funded through a separate assessment on employers. It was headed by a director who was appointed by the chairman, but reported to the board of commissioners.	The division's reporting lines were changed from the board to the chairman's office. Separate funding for the division was eliminated, and its expenses were incorporated into the commission's overall budget.
Workers' Rehabilitation Division: A statutorily mandated division charged with developing rehabilitative services for disabled workers. The division was funded through a separate assessment on employers. It was headed by a director who was appointed by and reported to the board of commissioners.	The division's reporting lines were changed from the board to the chairman's office. Separate funding for the division was eliminated, and its expenses were incorporated into the commission's overall budget.
District offices: Each of the eight offices had a statutorily specified geographic jurisdiction and was under the administrative control of the a commissioner who was specifically appointed to head one of the offices.	The statutory requirement for eight district offices located in specific municipalities with specified geographic jurisdictions was eliminated, and the offices' reporting lines were changed from the board to the chairman's office.
Commissioners: District commissioners were the chief administrative officers of the districts to which they were appointed by the governor and confirmed by the legislature, and had the power to hear and decide cases arising within the districts. At-large commissioners had the power to hear and decide cases arising within the districts to which they were assigned by the chairman.	All commissioners were given statewide jurisdiction, and their assignments were subject to the discretion of the chairman.
Advisory Board: Did not exist prior to passage of P.A. 91-339	Nine-member board (4 employee representatives, 4 employer representatives, & a neutral chair) established to advise the commission chairman on: - rules governing the operation of the commission - regulations - the annual budget & operating plan - standards and fees governing matters involving the provision of medical and legal services In addition the board was authorized to submit to the governor and General Assembly written comments on the reappointment of commissioners.

In 1993, Public Act 93-228 added to the chairman's powers and duties. Specifically, the act required the chairman to: adopt regulations governing the formation and operation of workplace safety committees; issue by October 1, 1993, maximum fee schedules for claimant attorneys; adopt

by October 1, 1993, a schedule of maximum medical fees payable for medical services provided to claimants; develop by July 1, 1994, medical practice protocols and utilization review procedures for reasonable and appropriate treatment of claimants; and submit to the governor and General Assembly written comments on the reappointment of commissioners.

The effect of P.A. 91-339 and P.A. 93-228 with respect to the commission's operation was to consolidate administrative power in the chairman's position. As outlined above, this was accomplished by: 1) switching the reporting lines and budgetary authority for all the commission's operating units to the chairman; 2) transferring to the chairman the powers held collectively by the commissioners when they were acting through the board; and 3) giving the chairman the authority to exercise several new powers assigned to the commission.

Responsibility for implementing the administrative changes was assigned to the chairman's position. The key tasks and their implementation status are outlined in Table II-3.

TABLE II-3.Key Administrative Responsibilities Assigned to The Chairman's Office

Responsibilities	Current Implementation Status
Establish workers' compensation districts and assign commissioners and staff	Completed -- Minor changes to statutory boundaries. Commissioners and other staff are assigned to district offices by the chairman and movement between offices is based on workload.
Establish an organizational structure that separates the administrative and adjudicative functions	Completed -- Hired district office managers to handle administration and case scheduling in July 1992, hired a chief administrative officer in August 1992.
Adopt rules to govern the commission's internal affairs	Chairman began issuing directives governing the commission operations in May of 1992
Establish employment procedures	The commission has in the past and continues to operate under the state's civil service system.
Establish staff development and training programs	On-going
Implement a uniform case processing and filing system	Completed -- Begun in May 1992, formalized with issuance of policy manual in June 1995
Develop standard hearing request forms and policies on maximum number of informal hearings permitted	Completed -- November 1994
Develop guidelines to expedite cases	Completed -- Begun in May 1992, formalized with issuance of policy manual in June 1995
Submit written comments to the governor and General Assembly on the reappointment of commissioners	Completed -- Begun with reappointments made in 1994

As shown in Table II-3 all of the requirements assigned to the commission's chairman have been implemented. Therefore, the program review committee finds that:

- *the centralization of administrative responsibility and authority in the office of the commission's chairman required by the 1991 and 1993 reform acts has been accomplished.*

Exercise of Authority

The committee staff undertook a three-pronged approach in assessing how the centralization of administrative authority is being exercised and the impact of that process on the system. Staff reviewed 96 directives disseminated under the chairman's authority between June 1, 1992, and May 30, 1995, interviewed and surveyed commissioners and district office administrators, and reviewed the minutes of 27 advisory board meetings.

Central office directives. The staff first classified all directives into one of four categories. While the categories used and the assignment of the directives to specific classes are somewhat subjective, this technique does provide a framework for the analysis. The four categories were:

(A) directives implementing statutory mandates governing workers' compensation such as cost-of-living calculations, fees schedules, etc.;

(B) directives governing the procedures for processing claims;

(C) directives governing employee behavior and general office procedures; and

(D) directives defining the commission's organizational structure, reporting lines, and authority of various staff positions.

Table II-4 shows the number of directives assigned to each category and the issuance period. The directives provided by the commission covered the period from early June 1992 through the middle of June 1995. Three 12-month issuance periods beginning with June 1992 were used for the time analysis.

The table shows that the largest single group of directives classified dealt with employee/office procedures (40). Directives in this category range from the greeting to use in answering the telephone to requiring offices to backup their computer files. The second largest category of directives involved those dealing with case processing procedures, such as the amount of time to allot for an informal hearing (22). Third, in terms of quantity, were directives stemming from statutory mandates such as cost-of-living adjustments and medical fee schedules (20). Last were directives detailing the authority of a staff position or defining reporting lines (14).

TABLE II-4. Classification of Central Office Written Directives					
Time Period	(A) Statutory Mandates	(B) Case Processing	(C) Employee/Office Procedures	(D) Structure Authority	Row Total
6/92 - 5/93	1	8	28	8	45
6/93 - 5/94	4	6	3	0	13
6/94 - 5/95	15	8	9	6	38
Total	20	22	40	14	96
Source of Data: Directives provided by the WCC					

In terms of time periods, Table II-4 shows that during the first and third periods a similar number of directives were issued, but the June 1993 through May 1994 period had a much smaller amount of activity. The high number of employee/office directives issued during the June 1992 through May 1993 period (28), is directly related to the appointment of a new chairman empowered with a strong statutory mandate (P.A. 91-339) to reorganize the administration of the commission. The relatively high number of directives in the statutory mandate category in the June 1994 to May 1995 time period (15) most likely reflects the lag time involved in developing and implementing many of the regulatory requirements contained in P.A. 93-228.

Recognizing that the quantity of directives in a category is not an indicator of the scope of their impact, the committee staff also examined the content of the directives. The review produced two somewhat contradictory findings. First, the directives show a central office moving quickly to fulfill its mandate to bring organization, uniformity, and accountability to a system that the program review committee's 1990 study found sorely lacking. On the other hand, the number and substance of the directives, particularly in the employee/office category, when viewed cumulatively paint a picture of a central office that is micro-managing its field operations.

Some of the more noteworthy examples of this management style: requiring vacation approvals to be granted three months in advance and filed with the central office (June 4, 1992); requiring hearing dockets to be forwarded to the central office two weeks in advance (August 26, 1992); requiring certain notices to be stapled into case files (January 22, 1993); banning directors from issuing memos concerning policy and procedures to their own staff without the prior approval of the chairman (January 27, 1993); issuing an automobile parking policy for district offices (April 26, 1993); and prohibiting commissioners from changing the dockets without the chairman's prior approval (October 5, 1994).

Staff survey. The committee surveyed commissioners and district office administrators to gauge their perception of the impact of the 1991 and 1993 legislative reforms on the overall administration of the compensation system. Responses were received from 13 of the 14 commissioners surveyed and all 8 of the district office administrators.[1] (The tabulated responses are included in Appendix B)

Fifteen of the respondents (75 percent) indicated that they viewed the administrative reforms enacted in 1991 as either positive or very positive. Only two respondents expressed a negative view, and three others offered no opinion. The 1993 administrative reforms were seen as positive by 12 of the respondents (60 percent), 4 indicated a negative view, and 4 others did not state an opinion.

The commissioners and administrators were also asked four specific questions pertaining to their view of the various units within the commission's central office. The units included the: chairman's office; chief administrator's office; district coordinator's office; business office; personnel office; management information systems unit; Compensation Review Board; and the Statistical Division. The questions asked the commissioners and administrators to give opinions concerning their relationship with, support received from, knowledge of, and the responsiveness of, each of the central office units.

Table II-5 presents the cumulative positive and negative responses of the commissioners and administrators to the four questions. The two groups differed only on their opinions of the business office and statistics division. The commissioners gave a positive rating to the business office and negative rating to the Statistical Division, while the administrators expressed the opposite view of both units.

The last column in the Table II-5 contains the ratio of positive to negative responses recorded for each office. A value greater than 1.0 means that there were more positive than negative responses. Using this scale, the Compensation Review Board and the chairman' office were rated highly, while the chief administrator's office, the district coordinator's office, and the management information unit did poorly.

Noteworthy of the responses to the specific questions was the overwhelming number of negative ratings given to most central office units on the question concerning their knowledge of the duties performed by commissioners and district office administrators. The chairman's office was the only office to receive positive ratings in this area from both the commissioners and administrators.

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[1] One of the 13 responding commissioners returned a blank survey.

TABLE II-5. Cumulative Response of Commissioners and District Office Administrators to LPR&IC Survey.							
Office Rated	**Commissioners**		**Administrators**		**Cumulative**		**+/-**
	Positive	**Negative**	**Positive**	**Negative**	**+**	**-**	**Ratio**
Chairman	33	15	24	8	57	23	2.5
Chief Administrator	12	24	14	17	26	41	.6
District Coordinator	16	24	10	18	26	42	.6
Business	28	13	13	19	41	32	1.3
Personnel	24	23	17	15	41	38	1.1
Management Information Services	10	27	15	15	25	42	.6
Compensation Review Board	45	3	26	15	71	18	3.9
Statistics Division	16	24	19	9	35	33	1.1
* The numbers do not include responses indicating no opinion.							

The major findings and conclusions of the committee with respect the commission's exercise of authority can be summarized as follows:

- *The administrative changes mandated by the 1991 and 1993 legislative reforms are viewed positively by a majority of the commissioners and district office administrators.*

- *The chairman of the Workers' Compensation Commission moved swiftly to bring organization, uniformity, and accountability to the administration of the workers' compensation system.*

- *Organization and accountability within the workers' compensation system have reached the point that the micro-management approach practiced by the commission's central office is no longer needed and its continuation is beginning to produce a negative attitude among staff.*

- *The chairman's office and the Compensation Review Board are highly regarded by a majority of the commissioners and district office administrators, but the chief administrator's office, district coordinator's office, and management information services unit are viewed negatively by a majority of the commissioners and administrators.*

- *All central office units except the chairman's office and the Compensation Review Board are perceived by most commissioners and district office administrators to have little knowledge of the work performed in the districts.*

The committee findings and conclusions indicate that there is a need for the commission to assess the relationship between the central office and the district staff. Although the problems may be rooted more in the perceptions of the parties than in reality, the differences should be addressed. Therefore, the program review committee recommends:

The Workers' Compensation Commission should prepare a policy statement for review and approval by the advisory board that outlines a role for commissioners and district office administrators in the development of administrative policies and procedures.

The Workers' Compensation Commission should develop an in-service training module that requires all central office managers to spend a specified period of time observing first hand and performing the tasks that are part of the routine functioning of a district.

The committee views the above recommendations as common sense solutions to relatively minor problems. However, if left untreated the dissatisfaction will grow as the commissioners and district office staff feel increasingly isolated and unsupported. The proposals are deliberately broad to give the commission's management an opportunity to develop methods that meet the objective of opening up the commission's administrative decision-making process. This should be done while top management still enjoys the good will of most commissioners and district office staff.

Advisory board. Public Act 91-339 created a nine-member advisory board composed of four employee and four employer representatives appointed by the governor and a neutral chair selected by the eight members. The purpose of the board is to advise the chairman of the Workers' Compensation Commission on matters pertaining to:

- rules governing operation of the commission;
- regulations issued by the commission;
- the annual budget and operating plan; and
- standards and fees governing the provision of medical and legal services.

In addition, the board is authorized to make written comments to the governor and General Assembly on the reappointment of workers' compensation commissioners.

The intent of the legislation was to provide employees and employers with a mechanism that could be used to oversee and influence the administrative policies governing the workers' compensation system and to serve as a check on the vast powers that have been assigned to the chairman of the Workers' Compensation Commission.

The review of the advisory board's activities focused on the minutes of its meetings. The minutes show the board met 27 times between March 1992 and June 1995, with an average attendance of six members. The minutes of four meetings, two executive sessions, and the last two meetings held were not available.

During 1992, the board concentrated on getting organized and defining its role. In terms of its specific responsibilities the members selected a board chair and made recommendations on two commissioners seeking reappointment. There was no evidence that any significant discussion of the commission's budget took place. The meetings did include informational updates on the commission's activities and occasionally the board members discussed specific policies, such as why a complicated case was given to a newly appointed commissioner. A total of nine meetings were held during 1992, and attendance averaged nearly eight members.

The minutes of the 1993 meetings show the board continued to struggle to define its role. Special attention was given to developing a procedure for evaluating commissioners, and the board strained to find a way to address specific issues, in particular the Second Injury Fund. Once again, there did not appear to be any significant discussion of the commission's budget. The minutes indicate the board's involvement in the development of administrative policies or regulations governing the workers' compensation system was limited to reacting to informational updates provided by the commission's chairman. Overall, eight meetings were held during 1993, and the average attendance declined to less than seven members.

The minutes available for 1994 and 1995 show that the board's meetings settled into the pattern established in 1993. The number of meetings fell to six in 1994, and the average attendance dropped to less than five. Although attendance averaged six members in 1995, the figure is meaningless since attendance was only available for two of the five meetings held through the end of November.

The committee believes that advisory bodies can go in one of two directions. They can be aggressive and use their official standing to influence actions, set agendas, and shape policies, or they can be passive and merely react to what is presented. The decline in frequency of meetings and member attendance reflected in the minutes may indicate the Workers' Compensation Advisory Board is headed in the latter direction.

The committee recognizes that often the success of advisory boards is linked to the ability of the board to exert its influence as well as the willingness of the receiving agency to seek and accept advice. It is difficult to legislate cooperation between the two. However, the committee maintains that a strong advisory board is critical to a well-run workers' compensation system and, therefore, recommends:

The Workers' Compensation Advisory Board must vigorously assert its authority and fulfill its responsibility to review and help shape the policies governing the administration of the workers' compensation system.

Financing the Commission

The budget of the Workers' Compensation Commission is not supported by the General Fund. Rather, it is financed through a special assessment levied on private sector employers and those municipalities that do not insure their workers' compensation liability through an interlocal risk management agency. Each employer's assessment is based on its workers' compensation-related expenses in the previous calendar year, but the assessment cannot exceed 4 percent of such expenses.

Shortly after the commission's operating budget has been finalized through the state's budget process, the chairman in consultation with the state treasurer determines the assessment rate needed to fund the commission's activities. Once the rate has been set, the state treasurer bills employers through their insurers or directly if the employer is self insured. Employers are required to make their payments within 60 days, and the receipts are deposited in the Workers' Compensation Administration Fund. Unlike agencies supported by the General Fund, the commission does not lose access to money that remains in the administrative fund at the close of each fiscal year. Surplus funds can be used to meet future expenses through rollovers from year to year.

The data in Table II-6 show that the commission has substantially overstated its budget needs in each of the last four state fiscal years resulting in surpluses of $8.0 million in FY 92, $2.5 million in FY 93, $7.5 million in FY 94, and $9.5 million in FY 95. It is noteworthy that in the middle of running up a $7.5 million surplus in FY 94, the commission requested -- and was granted -- a $2.1 million upward adjustment to its previously approved FY 95 budget. As a result of its financial management practices, the commission entered FY 96 with reserves in excess of $21.3 million.

Table II-6. Workers' Compensation Commission Finances FY 92 - FY 95

	FY 92	FY 93	FY 94	FY 95
Approved Budget	$22,798,996	$21,477,335	$26,174,580	$29,189,764
Assessment	$22,649, 525	$21,678,550	$25,168,858	$23,474,832
Assessment Rate	3.9%	3.5%	4.0%	3.6%
Receipts	$29,386,910	$15,842,560	$25,272,000	$23,036,425
Expenditures	$14,813,410	$19,156,756	$18,432,133	$19,746,586
Cash Balance 6/30	$14,573,500	$11,259,304	$18,099,171	$21,389,010

Source of Data: State Comptroller, State Treasurer, WCC

Despite this record of significantly overstating its budget needs, the commission has consistently sought an assessment rate that virtually ignores the surplus in the Workers' Compensation Administration Fund. For example, in FY 95 the commission's approved budget was $29.2 million and its reserves totaled $18.1 million. Against this backdrop the commission sought $23.8 million through the employers' assessment (a rate of 3.75 percent) and indicated that it would draw the remaining $5.4 million from reserves in the administration fund. After the state treasurer questioned the 3.75 percent assessment rate, the commission settled on a rate of 3.62 percent, which yielded revenues of slightly more than $23 million. Ultimately the commission expended $19.7 million in FY 95, 33 percent less than its appropriation, resulting in another $3.3 million being added to its reserves.

In response to inquiries from the program review committee the commission cited two reasons for the large reserves in its administration fund. First, the commission stated that the reserves were needed to meet future costs associated with implementing its new computer system. However, in the opinion of the committee this rationale is a weak justification given the size of the reserves and the fact that it is would be almost impossible for such an expenditure to be allowed without a specified appropriation.

The Workers' Compensation Commission also claimed that it needed large reserves because without a sufficient balance in its administration fund, Office of Policy and Management (OPM) would not be able to allot enough money to meet the commission's financial obligations during the first quarter of each state fiscal year (July 1 - September 30). A check with OPM found this explanation to be not totally accurate. Staff at OPM indicated that if the commission's administration fund was insufficient to meet the agency's first quarter financial demand the shortfall would be made up with money from the General Fund. The staff noted that, although OPM takes a dim view of the practice, the General Fund could be reimbursed for the loan when the commission's assessment is collected.

However, the necessity for ever having to use General Fund money in this manner is questionable. The assessment is typically imposed during the later stages of the first quarter of the state fiscal year with all but delinquent collections being deposited in the administration fund by the end of the second quarter (December 31). Given that the assessment is designed to meet 12 months of operating expenses, it would seem reasonable to assume that such a schedule should provide sufficient funds at the close of the state fiscal year to cover the commission's expenses through the second quarter of the subsequent fiscal year.

In the opinion of the committee, if the commission has a problem associated with its first quarter allotment, it is a cash flow matter. This should be manageable through a variety of administrative actions such as timing nonessential purchases and other discretionary expenses to coincide with periods of adequate fund reserves. Based on its review, the committee concludes that:

- *the Workers' Compensation Commission's budget requests have consistently and substantially overstated the commission's needs; and*

- *the Workers' Compensation Commission has pursued a policy aimed at generating or maintaining larger than necessary reserves.*

For example, this year, with a great deal of fanfare, the commission announced that it was reducing its assessment rate to 3 percent from the FY 95 rate of 3.6 percent. However, this assessment is projected to produce about $18 million in receipts, which coupled with an existing surplus of roughly $22 million will still give the commission a revenue pool of more than $40 million to meet its FY 96 budgeted expenses of $21 million.

To prevent the unnecessarily high assessments on state businesses from continuing, the program review committee recommends:

Reserves in the Workers' Compensation Administration Fund determined by the state comptroller to be in excess of $5,000,000 shall be used to reduce the annual assessment on employers to finance the operations of the Workers' Compensation Commission.

The recommendation modifies the current assessment procedure to assure that when a substantial surplus occurs in the commission's operating fund the money will be used to reduce the next assessment on employers. This is similar to the restriction imposed on the use of reserves in the special fund for financing the Connecticut Department of Banking, although the statutes governing the banking fund allow OPM to set a new contingency reserve limit each year.

The data in Table II-7 show that had this recommendation been in effect it would have resulted in lower assessments in each fiscal year from 1993 through 1996. The cumulative savings to Connecticut businesses during the period would have been $18.6 million. The assessments shown in the table for FY 93 and FY 96 illustrate that under the proposed financing method a large surplus would be immediately funneled back to businesses in the form of a reduced assessment.

TABLE II-7. Comparison of Proposed Recommendation for Financing the WCC with Actual Practice ($ in millions)

	FY 92	FY 93	FY 94	FY 95	FY 96
Actual Assessment	$22.6	$21.7	$25.2	$23.5	$18.2
Proposed Assessment	$23.2	$12.3	$23.8	$21.4	$11.6
Savings to Employers	($0.6)	$9.3	$1.3	$2.0	$6.6
Reserves under proposal	$14.1	$7.3	$12.7	$14.4	NA

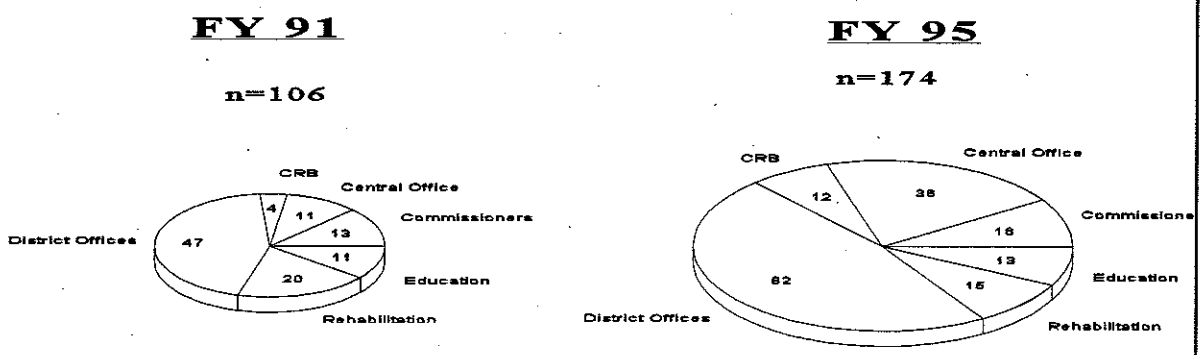
Staffing

In analyzing the centralization of responsibility and authority within the commission, the committee examined changes in the allocation of the commission's staff. The analysis focused on comparing the distribution of staff among the commission's functions in the pre- and post-reform periods, as typified by FY 91 and FY 95 respectively.

The staff at the commission increased significantly during the four-year period (68 positions).[2] The district offices were assigned the most new staff (35), followed by the central office (25), and the Compensation Review Board (8). The number of commissioners increased by three, and two staff were added to the Education Division. The size of the Rehabilitation Division was reduced by five. The latter two divisions were eliminated as statutory entities by P.A. 95-265, but remain as defined functions within the commission.

Change in an office's share of total staff was used as a measure of a function's relative priority within the commission. Under this approach, which takes into account the 65 percent overall staff growth rate, the direction and magnitude of the change indicates the degree of value placed on an office. The two pie charts in Figure II-8 illustrate the growth in the commission's overall staff and changes in each office's share of total staff between FY 91 and FY 95. The results show that the central office, which tripled its size and doubled its share of the total staff, was the commission's top priority. The district offices, despite receiving the largest number of new staff (35), ranked lower on the priority scale, with only a marginal increase in staff share (3 percent).

FIGURE II-8. Changes in the Growth and Distribution of the Commission's Staff

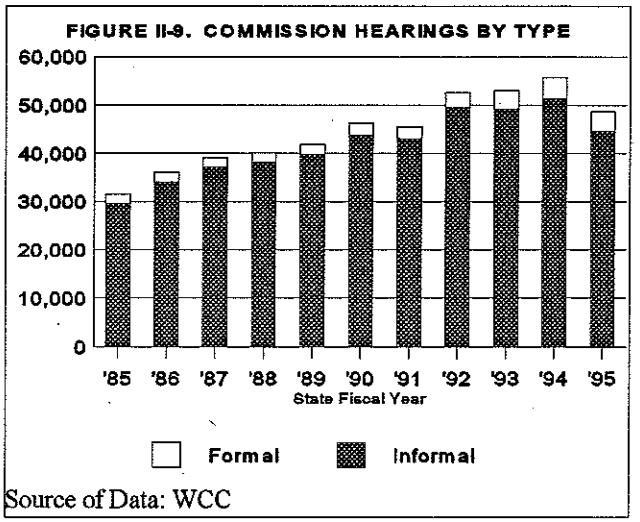


[2] Included are all staff that work 34 hours or more per week.

Performance

As previously noted, the intent of the administrative changes introduced by P.A. 91-339 and P.A. 93-228 were to improve the commission's responsiveness to all participants and increase its productivity and efficiency. The assessment of the effectiveness of the changes is limited to basic input and output measures including the: number of hearings held; decisions reported; time required to move cases through various steps in the process; and overview of the case processing.

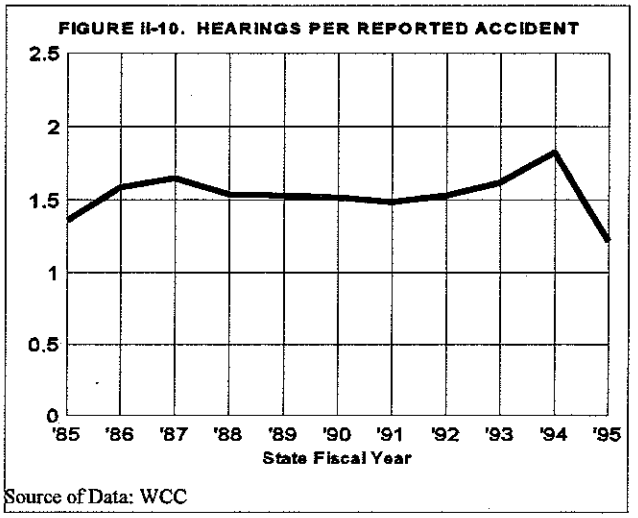
Hearings held. Figure II-9 graphs the number of informal and formal hearings held annually by the commission from FY 85 through FY 95. The graph shows a generally rising trend for both hearing types over the entire 10-year period, with a noticeable upward shift beginning in FY 92. Although FY 95 does show a decline of 13 percent from the previous year, it is to early to determine if this represents a trend change.



Source of Data: WCC

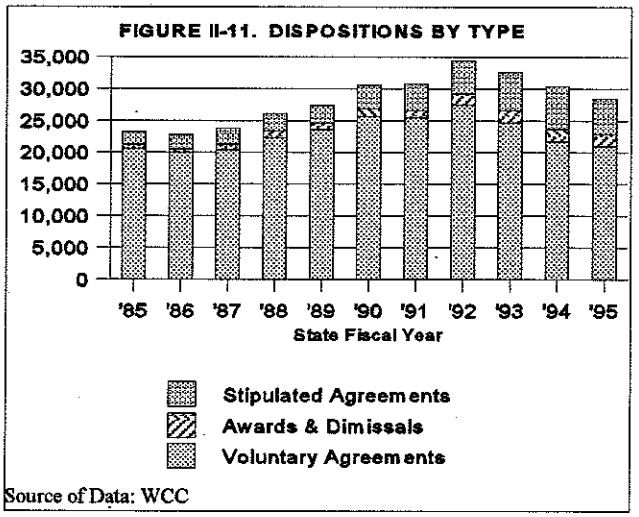
A primary contributor to the upward shift begun in FY 92 was the authorization of one new commissioner in that year (P.A. 91-339) and two more in FY 94 (P.A. 93-228). Indeed, the 22 percent increase in the number of hearings held in FY 94 compared to FY 91 approximates the 23 percent increase in the number of commissioners during the period.

Figure II-10 plots the number of hearings held per reported accident. If changes in the total number of hearings held were caused solely by changes in the number of reported accidents, then the line plotted in the graph would be flat. The fact that the line is not indicates that the upward shift in the number of hearings held that began in FY 92 is due to factors other than an increase in the number of reported accidents. Whether the increase is a result of more attention being given to backlogged cases or reflects an increase in the number of hearings per case could not be determined.



Source of Data: WCC

Dispositions reported. Dispositions represent the basic output measure of the commission's activity. As reported by the commission and shown in Figure II-11, total dispositions are composed of: voluntary agreements (forms signed by the parties indicating that benefits are being provided and generally require minimal commission involvement); awards and dismissals (formal decisions of commissioners typically rendered after several hearings); and stipulated agreements (settlements negotiated by the parties, usually after a commissioner's involvement, and typically close a claim when approved by a commissioner). Figure II-11 shows that total dispositions have declined sharply since peaking at 34,439 in FY 92. This raises a question about the effect of the administrative reforms on the commission's output.



Processing time. The committee's 1990 study found the waiting time for a routine informal hearing was 6 to 7 weeks, while a formal hearing required a wait of 7 to 10 weeks. In July and August of 1995, district office administrators reported that the waiting time for a hearing was 4 to 6 weeks for an informal and 6 to 8 weeks for a formal hearing. Thus, since passage of the administrative reforms the waiting times for hearings have decreased.

It should be noted that requests for emergency hearings, primarily those involving a claimant not receiving any benefits, have always been accommodated on an accelerated basis. The difference between the pre-1991 reforms and now is that under the old system such hearings were simply squeezed onto the daily docket, while under current procedures specific times have been built into the docket to deal with emergencies.

Case processing sample. The committee collected data on 175 workers' compensation cases that had at least one formal hearing during March 1995. The purpose of the review was to assess how well the Workers' Compensation Commission was handling its dispute resolution responsibilities. Cases that involved a formal hearing were selected to insure the sample provided an opportunity to analyze the full range of the commission's case processing procedures.

A profile of the sample shows that, based on the claimant's injury date, nearly half of the cases (48 percent) involved injuries that occurred after the 1991 mandated administrative reforms began to be implemented by the commission in July 1992. Slightly more than 25 percent of the cases were subject to the benefit changes introduced by P.A. 93-228. In terms of current case status: 92 cases (53 percent) were classified as *closed*; 49 were *open* with the future involvement of the commission unspecified; 21 had a hearing pending; 4 dispositions were being appealed to the Compensation Review Broad; and 6 cases were classified as *other*.

Type of issue contested and resolved. Table II-12 shows the distribution of the contested issues recorded by the committee staff as being part of the record of the first and last informal, pre-formal, and formal hearings. Issues that surfaced or were resolved at hearings other than the first or last hearing are not included in the Table II-12. Despite the limitations, the data in the table are a good indication of the type of issues involved and resolved at each hearing level.

The data show that employer liability was the most cited issue at all three hearing levels -- informal, pre-formal, and formal -- followed by medical treatment or payments for medical services. It is noteworthy that the most frequently cited issues at all three levels of the commission's dispute resolution process involved the system's basic benefits for injured workers. As would be expected, these issues are also the most frequently resolved disputes at each hearing level, though in far fewer numbers.

Table II-12 shows that the category labeled *other*, which includes such matters as attorney fees and apportionment of liability among insurers was the third most frequently contested issue category at all hearings. However, it ranked as the third-highest category in dispute resolutions only at the formal hearing stage. It was fourth in resolutions at the informal hearing stage, and tied for last at the pre-formal level. The Second Injury Fund (SIF) transfer issue seems to follow a similar pattern. The committee believes this is an indicator that, as more parties become entangled in the claim (e.g., attorneys, additional insurers, the SIF, etc.) the more difficult it is to resolve.

Table II-12. Number of Contested Issues Involved at First and Last Hearing at each Hearing Stage

Issue Category	# Issues Involved Informal	# Issues Resolved Informal	# Issues Involved Pre-Formal	# Issues Resolved Pre-Formal	# Issues Involved Formal	# Issues resolved Formal
Employer Liability	158	24	53	2	142	82
Medical (Pay/Treat)	97	13	31	3	83	59
Perman. Partial Disa.	53	3	11	2	49	37
308a Benefits	33	11	2	0	14	6
Return to Work	11	2	4	0	7	6
Timely Payments	26	5	9	5	20	10
SIF	26	1	6	1	41	28
Other	59	8	21	0	58	43
Misc.	10	0	2	1	9	6

Source of Data: Sample of 175 cases that had a formal hearing in March 1995.

The data in the Table II-12 indicates that only at the formal hearing stage are issues resolved in any significant numbers. Here, the resolution rate for disputed issues was 50 percent or greater for all but one category -- *308a benefits* -- included in the sample. However, since the data included only cases that went to a formal hearing, that would be expected.

Dispute Outcomes. Data on which party appeared to be favored by the decision was collected only for decisions rendered after formal hearings. In many cases it was difficult to determine precisely which side was favored. In general the committee took a broad view and recorded the claimant as the favored party if the person received some measure of what they were seeking as a result of the decision. However, it must be recognized that this overstates the number of times the claimant was totally favored by the result. For example, a stipulated agreement that awards benefits in a contested liability case would be recorded in the data as favoring the claimant, but in reality the agreement might favor the employer because he or she ended up providing only minimal benefits. Using this approach, the committee found claimants were favored in 81 percent of case decisions and employers in 16 percent. The remaining 3 percent were either mixed or involved third parties.

Hearings. The committee examined the number of hearings held on the 175 cases in the sample. Averages were calculated by type of hearing for: the sample as a whole; cases for which a disposition was reported after the March 1995 formal hearing; and cases in which no decision has yet been rendered (as of early December 1995). The results are shown in Table II-13.

Table II-13 illustrates a number of factors concerning the commission's processing of cases. First, the commission has not had great success in meeting an objective of the administrative reforms -- limit the number of informal hearings. Second, the fact that the average number of pre-formals is less than one per case for all groups indicates the commission's stated procedure of holding a pre-formal prior to a formal hearing is not always followed. Lastly, the *no decision* group (last column) recorded the highest average hearings per-case in all three hearing categories.

The committee, based on the high number of *no decision* cases, concluded there are a substantial number of cases that are not prone to a quick resolution. The committee believes the commission should, when its automated information system is fully functional, develop a procedure to identify such cases so they can be placed on a track that moves them more quickly toward a formal hearing and final decision.

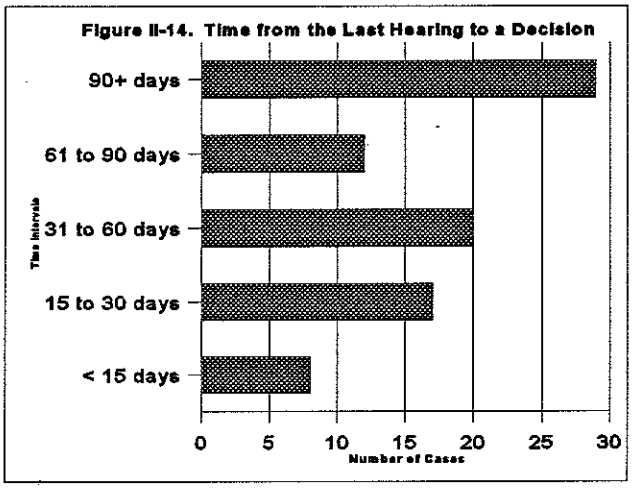
Table II-13. Average Number of Hearings by Type

Type of Hearing	All Cases (n=175)	Cases with a Disposition (n = 119)	Cases without a Disposition (n = 56)
Informal	3.3	3.2	3.4
Pre-Formal	0.7	0.7	0.9
Formal	2.1	2.0	2.2

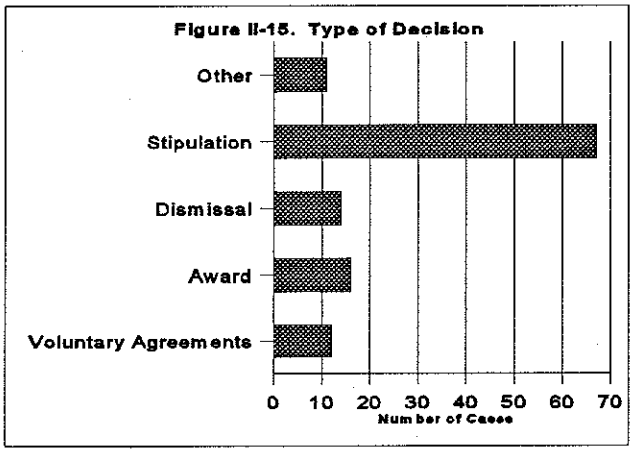
Source of Data: LPR&IC Case Sample

Time taken to reach a decision. In analyzing the time taken to reach a decision, the committee focused on the group of cases (119) in which a decision had been reported. It is important to note that the time measured was from the last formal hearing to the decision date. In most cases the time from the date of the claimant's injury or even the initial commission hearing to a final decision would be considerably longer.

The data showed the average number of days from the last formal hearing to the issuance of a decision was 58 days, with a median of 41 days. However, included in this group were 27 cases in which the sole purpose of the last scheduled formal hearing ended up being the approval of a stipulated agreement or settlement between the parties. Removing these cases increases the average time from the last hearing to a final decision to 76 days and raises the median to 59 days. The distribution of cases falling into selected time intervals is shown in Figure II-14. Given the complexity of the disputed issues and the effort made to encourage the involved parties to reach a settlement agreeable to both sides, the committee did not find that the amount of time taken to arrive at a resolution after the last formal hearing was unreasonable.



Type of decision. The final area examined by the committee dealt with the type of decision rendered after the last formal hearing. Figure II-15 shows the distribution of decision types among the 119 cases in which a decision was reported. The graphic illustrates that nothing comes close to the number of dispositions falling into the *stipulated agreement category*. It is important to note that not all decisions close a case. Even a commissioner's award (13 percent of the decisions) or dismissal (12 percent of the decisions) can be confined to a narrow issue and not completely close the case. The same is true of stipulated agreements, where the committee determined at least 7 percent of the 67 agreements were not a full and final settlement of the case.



The committee believes that the relatively large number of stipulated agreements, coupled with the steep decline in the voluntary agreements sent to the commission for approval, reflects a growing tendency on the part of employers and their insurers to use formal means to settle workers' compensation disputes. If stipulated agreements or settlements are the end result in a majority of the difficult cases, then the commission needs to assess how it can get the parties to this point in less time and with fewer hearings.

Processing appeals. The workers' compensation system provides an administrative appeals level to review decisions made by commissioners. The appeals are heard by the Compensation Review Board, which is composed of the chairman and two other commissioners who are appointed by the chairman for a one-year period. The chairman may appoint a third member to sit on the board for cases where a board commissioner must disqualify himself or herself for any reason, including because he or she issued the decision being appealed.

By statute, the CRB only hears appeals concerning legal inconsistencies or errors in factual findings; cases are not heard de novo. Appeals may be made on commissioner's awards, commissioner decisions made upon a motion, or after a commissioner issues an order on apportionment of compensation among employers. In addition to affirming or reversing decisions on the award or dismissal of claims, orders, and rulings on procedural motions, the board may remand a case to the trial commissioner for further proceedings.

Petitions for a CRB review must be filed within 10 days of the trial commissioner's decision. There are no filing costs to the parties for bringing an appeal. The statutes require that the board issue its decision within one year from the date the appeal was filed.

Table II-16 shows key indicators related to appeals from FY 90 through FY 95. The table illustrates that the total number of appeals has been increasing in the workers' compensation system since the Legislative Program Review and Investigations Committee conducted its last study of the system in 1990.

As the data show, overall the number of appeals has grown dramatically in the six-year period. In FY 90 there were 174 appeals; by FY 95 the number had grown to 325, an 87 percent increase. The biggest increase occurred between FY 92 and FY 93, when the appeals grew from 195 to 323 appeals. Since FY 93, the number of appeals has remained above 300. The number of commissioners' findings and awards (the decisions that are appealable) have also grown --from 1,193 in FY 90 to 1,943 in FY 95. This translates to a rise of 63 percent, which is certainly significant, but lags behind the 87 percent growth in appeals themselves.

When the appeals are taken as a percentage of decisions on a yearly basis, the growth has not been as significant. In FY 90, 14.6 percent of commissioner decisions were appealed, while in FY 95 that percentage was up to 16.7 percent. Thus, aside from a one-year drop in FY 92 to 11.3 percent, the percentage of decisions appealed has remained virtually unchanged -- at about 15 to 17 percent -- over the past six years.

Table II-16. Workers' Compensation Appeals FY 90 – FY 95					
Fiscal Year	**# Appeals**	**Comm. Decisions**	**Appeals as % of Decisions**	**No. Disposed**	**Written Decisions**
FY 90	174	1,193	14.6%	171	98
FY 91	190	1,128	16.8%	183	103
FY 92	195	1,724	11.3%	178	96
FY 93	323	1,913	16.9%	189	99
FY 94	316	1,967	16.1%	290	147
FY 95	325	1,943	16.7%	347	208
% Growth '90-'95	87%	63%	14%	103%	112%
Source of Data: WCC Administrative Reports					

Despite the fact that the percentage of decisions that go to appeal has not changed radically, the system issues more formal decisions, which generate more appeals, and the system must respond to that. The data seem to indicate the system has kept pace with the increase and prevented a large backlog from developing. The Compensation Review Board and its staff have disposed of 1,187 of the 1,349 appeals generated over the past six years. Further, in FY 95 the board disposed of twice as many appeals as it did in FY 90.

However, the time it takes for an appeal to be heard and decided has increased during the six-year period. When the committee conducted its review in 1990 it found that the (then) Compensation Review Division was not meeting its one-year statutory deadline to issue decisions on appeals. The appeals division was generally taking about 16 to 17 months to issue a decision at that time. Committee f recently reviewed an automated database of workers' compensation appeals decisions issued between 1992 and 1995, and found the average time for a decision has now increased to approximately 20 months. Thus, despite the increase of more than 200 percent in support staff in the appeals section, the board remains unable to meet its statutory requirement for decisions to be issued.

The committee recognizes that the growth in the number of appeals certainly impacts on the time frame for the issuance of decisions. Another problem may be that inappropriate petitions for appeals are being made to the Compensation Review Board. In its case file review, the committee found that a few files contained petitions for appeals on matters other than Findings and Awards of a commissioner issued after a formal hearing. For example, one case contained a petition to appeal from an approved form 36, the form an insurer or employer uses to notify the claimant and the commission that it will discontinue or decrease benefits based on a physician's determination that the claimant can return to some form of work. The approval of a form 36 would not seem to meet the statutory criteria of an official decision that could be appealed.

The commission has already increased support staff in the appeals area, as this committee recommended in 1990, but further steps are needed to handle the press of appeals and meet the time frame required by statute. Therefore, the program review committee recommends that:

The chairman of the Workers' Compensation Commission examine ways for the appeals board to expedite the processing of appeals such as:

- **allotting additional time for the board to meet and hear appeals;**
- **establishing clear policies concerning the criteria for which a petition for appeal will be accepted, and communicating those policies to commissioners, staff, insurance companies, and the claimants' and respondents' bar; and**
- **requiring CRB support staff to screen the petitions for appeals to ensure they meet the criteria established before being set down for board review.**

Productivity and Efficiency

The commission's productivity and cost efficiency were measured in terms of relative changes in inputs (expenditures and staff) and outputs (hearings held and dispositions). Averages for the four years preceding, and the four succeeding, initiation of the administrative reforms were used to minimize the effect of year-to-year volatility in the workload caused by factors beyond the control of the commission, such as changes in the number of workplace accidents. The data presented in Table II-17 show that the two basic input measures -- expenditures and staff -- increased more than 50 percent each, and the two basic measures of output -- hearings and dispositions -- increased 20 and 11 percent respectively. The fact that expenditures and staff increased at faster rates than hearings and dispositions indicates that, at least in global terms, the commission has experienced a decline in output-per-worker and cost-per-output.

TABLE II-17.Comparison of Key Statistics for the Pre-Reform and Post-Reform Periods

Category	Pre-Reform FY 88 - FY 91	Post-Reform FY 92 - FY 95	Percent Change
Average Expenditures	$11,998,569	$18,698,353	55.8%
Average Number Staff	88	135	53.4%
Average Number Hearings	43,530	52,356	20.3%
Average Dispositions	28,681	31,845	11.0%

Source of Data: State Auditors , Governor's Budget, WCC Annual Statistics, Administrative Reports

To refine the analysis, modifications were made in the cost measures, and several additional ratios were constructed. The results after adjusting expenditures for inflation still show cost-per-output increased in the post-reform period -- the cost per hearing rose 12.9 percent (from $255 to $288) and the cost per disposition increased 22.3 percent (from $388 to $474). However, the expenditures in the post-reform period include employee fringe benefits and indirect costs, expenses for which the commission was not assessed by the state in the pre-reform period. When these expenses are excluded, a different result emerges. As shown in Table II-18 the cost-per-disposition still increases, but by a much smaller amount (5.7 percent) and the cost-per hearing actually declines -- down 2.5 percent. [3]

The ratios measuring productivity show similar results. When total commission staff are used, hearings and dispositions per staff decreased by 21.6 percent and 27.6 percent respectively. The sharp decline is likely related to the large increase in personnel in support areas not directly involved in processing cases or resolving disputes. Unfortunately, the number of staff performing these activities could not be accurately identified for each of the four years preceding and the four years succeeding the initiation of the reforms, and thus could not be used in calculating real changes in productivity. The best that could be done was to use the number of commissioners, which were known for each year, as a proxy for case processing staff. However, it must be noted that this grossly understates the staff involved in this area. The result obtained using this method shows that the commission's hearing productivity improved slightly between the pre- and post reform periods (3.7 percent), while its productivity in disposing of claims did not (-4.0 percent).

In summary, measures of the change in the commission's output to input ratios since the implementation of the administrative reform are mixed. Using global indicators, productivity and cost efficiency declined. However, when adjustments are made in the commission's inputs (expenditures and staff), productivity and cost efficiency improve in the process area (hearings), but not in the area of dispositions (a bottom line measure). Based on these findings and the staff allocation data the program review committee concludes:

- *improvements in the cost efficiency and productivity of the commission's operations are limited by the assignment of too many staff to functions not directly involved in processing claims and rendering decisions;*

- *at best, the improvement in the commission's cost efficiency in processing workers' compensation claims has been minimal; and*

- *there has been a decline in the commission's cost efficiency and productivity in disposing of workers' compensation claims.*

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[3] To accommodate those who argue that the initial investment associated with designing and implementing the commission's new computer system should be distributed over the life of the system, cost ratios were calculated that spread the computer costs over five years. When factored in with the fringe benefits and overhead adjustments the results show the commission's cost-per-hearing in the post-reform period fell 5.2 percent and the cost-per-disposition increased 2.7 percent.

TABLE II-18. Comparison of Key Input/Output Ratios of the Pre-reform and Post-Reform Periods			
Category	**Pre-Reform FY '88 - FY '91**	**Post-Reform FY '92 - FY '95**	**Percent Change**
Cost per hearing *	$255	$249	-2.5%
Cost per disposition*	$388	$410	5.7%
Hearings per staff	495	388	-21.6%
Dispositions per staff	326	236	-27.6
Hearings per commissioner	3,627	3,761	3.7%
Dispositions per commissioner	2,390	2,295	-4.0%
Hearings per disposition	1.52	1.64	7.9%

* In constant 1988 dollars.
Source of Data: All output and FY 95 expenditures data were provided by the WCC. State Auditors provided all other expenditure data

In the opinion of the committee, the increase in the overall number of hearings and the decline in the commission's productivity and efficiency in rendering decisions is related to an increase in litigiousness in the system. This increase can be seen in two factors. First, the four-year pre- and post-reform averages show a rise of 8.3 percent in the number of hearings per disposition. Second, there is a noticeable shift in the type of dispositions reported by the commission. The pre- and post-reform averages show that awards and dismissals are up 69.3 percent, stipulated agreements have increased 74.1 percent, but voluntary agreements are down 1.6 percent.

The decline in the voluntary agreements has been more precipitous than the average suggests. Over the last three years, the number of dispositions attributed to voluntary agreements has fallen 21 percent. In the opinion of the committee the decline has been a major contributor to the decrease found in the commission's productivity and cost efficiency. In the past such agreements played a major role in helping the commission move its business (see Figure II-11), generally requiring only minimal resources compared to those needed to obtain and approve stipulated agreements or issue awards and dismissals. The trend away from voluntary agreements to more formal settlements has had a serious impact on the commission's resources

Several theories have been offered to explain the decline in voluntary agreements. Among the most plausible are: 1) the 1993 reform act changed the law allowing employers and their insurers to make payments without prejudice and gave a full year in which the employer could contest liability; 2) the increased ability of the commission to provide hearings in a timely manner; 3) a desire on the part of employers and their insurers to seek a final settlement rather than enter a voluntary agreement

that can be reopened; and 4) a commission focused toward emphasizing formal settlements and exhibiting an indifference toward voluntary agreements.[4]

Each of these explanations is associated with a reduction in the pressure on one or more of the parties to settle the claim through a voluntary agreement. Regardless of the cause, the drop in voluntary agreements has resulted in a decline in the disposition type that demands the least commission resources and has thus contributed to a decline in productivity and cost efficiency. Based on these conclusions, the program review committee recommends:

The Workers' Compensation Commission should assess its current allocation of personnel and put greater emphasis on placing staff in positions directly involved in processing claims and rendering decisions.

The Workers' Compensation Commission should assess its role in the decline in the use of voluntary agreements to dispose of claims and together with its advisory board develop policies that will encourage workers and employers to make greater use of this alternative.

The committee believes that such policies should include reminding employers and insurers of their obligations under C.G.S. Sec. 31-296 to submit voluntary agreements in writing to the commission for approval. The policies should also emphasize to employers and insurers that even though the period for contesting liability was greatly lengthened (from 28 days to 1 year), once employers have accepted liability they must file a voluntary agreement.

Survey of Business and Labor

The committee surveyed 415 randomly selected businesses and 450 labor leaders concerning their opinions on the 1991 and 1993 reforms. The survey responses indicate that neither business nor labor strongly endorses the administrative reforms. However, the low return rates -- 13 percent for business and 14 percent for labor -- require that great caution be used in interpreting the results. With this caveat, some of the highlights are presented. (For the tabulated responses, see Appendix C -- business -- and Appendix D -- labor.)

In answering a question concerning how easy it was to get a hearing before a commissioner, just 17 percent of the 53 businesses responding stated that it was easier in the post-reform period. Only 20 percent of the 61 labor respondents stated a belief that it is easier to file a claim after the reforms, 30 percent felt that it was more difficult, and 50 percent saw no change. The low response rate may also reflect a tendency for those holding strong negative views to respond at higher rates than others.

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[4] In testimony presented at the program review committee's September 5, 1995 public hearing, the chairman of the commission noted that when an employer and employee agree on payments voluntary agreements are not necessary.

A question concerning the fairness of the commission's decision-making drew an interesting response. While a majority of the labor respondents (55 percent) indicated that the post-reform commission is fair, this is 22 points less than 76 percent that viewed the pre-reform system as fair. The opposite view was provided by business respondents. Only 35 percent stated a belief that the post-reform commission is fair, but this is an increase over the 15 percent that viewed the pre-reform commission as fair to employers.

Based on the overall responses to the survey and assuming an equal tendency for business and labor representatives holding strong opinions to respond, the committee finds that:

- *overall, labor is more positive than employers about the current administration of the workers' compensation system.*

- *labor is more positive about the fairness of the system in the pre-reform than the post-reform period, while employers are more positive about the post-reform than the pre-form fairness of the system.*

CHAPTER III

WORKERS' COMPENSATION INSURANCE: COVERAGE, RATES, PREMIUMS, AND PROFITABILITY

Background

All employers who use the services of one or more persons for pay must cover their workers' compensation liability in Connecticut. They can do this by purchasing private insurance, self-insuring, or a combination of both. Employers must post evidence of coverage in a conspicuous location. The Workers' Compensation Commission has also promulgated regulations concerning what the posting should contain.

The two pieces of reform legislation did not substantially change the requirements for workers' compensation insurance coverage. Prior to the passage of P.A. 93-228 business partners were not covered by workers' compensation unless they expressly notified the Workers' Compensation Commission that they were accepting coverage. Public Act 93-228 required that partners be covered by workers' compensation insurance, unless all partners in the business notify the WCC in writing that they waive coverage. The document must be signed by all partners.

Methods of Covering Workers' Compensation

Private Insurance. The most common method employers use to cover their exposure under workers' compensation laws is to purchase insurance from private carriers. All private workers' compensation insurance carriers must be licensed by the Insurance Department to do business in Connecticut. Companies are regulated by the department to ensure financial solvency, to confirm that the policies and forms meet department standards and guidelines, and that the rates filed are neither excessive nor inadequate. Rates and rate regulation are discussed later in this chapter. A significant number of insurance companies currently write workers' compensation in Connecticut. While the number fluctuates each year, between 100 and 150 companies write more than $500,000 each in premiums annually.

High deductibles. The statutes also permit employers to cover their risks through a combination of insurance and self-insurance. The most common approach to this is the high deductible insurance policy. The statutes have permitted policies with deductibles to be sold in Connecticut since the early 1980s, however, they were not marketed or sold here until 1991.

These deductible programs are regulated by the insurance department. The department requires that documentation of the deductible be on file with any policy offering such deductible programs. Further, the department requires that each insurance company pay the claim amounts in full and then seek reimbursement of the deductible amounts from the employer, and that each

insurance company be responsible for securing collateral from the employers to cover the amounts up to the deductible. In 1994, approximately $200 million of workers compensation liability was retained by companies using such high deductible programs, according to the National Council on Compensation Insurance.

Self-insurance. Businesses may also decide not to purchase any workers' compensation insurance, but to self-insure totally. In order to self-insure their exposure for workers' compensation, employers must provide the chairman of the Workers' Compensation Commission with satisfactory proof of solvency and potential ability to pay compensation provided by statute. Renewals for self-insurance must be granted each year.

According to material the committee received from the commission, documentation required and examined by the commission before self-insurance authority is granted include the following:

- ***proof of stability and solvency.*** This includes the number of years in business, the history of corporate activity such as stock sales and acquisitions, and the three most recent years of independently audited annual financial reports.

- ***evidence of risk exposure*** including actual loss history. The commission requires submission of total Connecticut payroll figures for the past three years, and a breakdown of the last three complete years of incurred medical and indemnity claims, including paid and open amounts.

- ***requirements for security.*** Generally, the commission requires that all new self-insurers post a surety bond to secure the payment of claims, usually in an amount equal to the amount that is self-insured. Excess insurance is required to cover catastrophic losses.

- ***claims administration.*** The Workers' Compensation Commission requires that all self-insurers provide adequate claims administration for delivery of benefits, including proof of adequate staff and expertise to perform functions in-house, or identification of the third party administrator that will handle the claims. The WCC requires the claims administrator to conduct the claims adjustment in Connecticut.

The statute also allows groups of similar businesses or industries to apply to the state Department of Insurance to self-insure, but the department has placed strict requirements for the establishment of these groups, which will be discussed later in this chapter.

Most employers do not cover their workers' compensation liability solely through self-insurance, although that number appears to be growing. The Office of the State Treasurer keeps track of all self-insurers in the state with workers' compensation losses during that year, so that they can be assessed for the Second Injury Fund. Because there is no clearly accurate number of self-

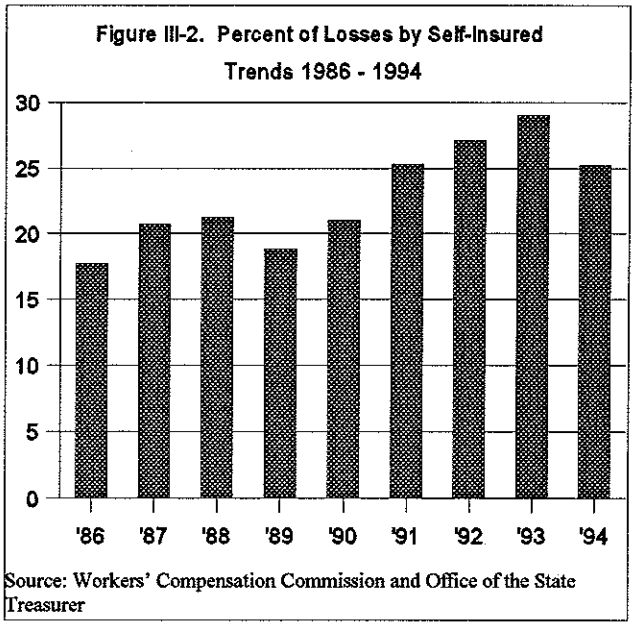
insured businesses, the program review committee used this number to approximate the number of employers each year who self-insure. The data, shown in Table III-1, indicate the upward trend in this number.

Table III-1. Growth in the Number of Self-Insurers.

Year	1991	1992	1993	1994	Increase 1991-1994
Number	134	149	153	157	23
Percent Change		11.2%	2.7%	2.6%	17.1%

Source: Second Injury Fund, Office of State Treasurer

Probably more notable than the growth in the numbers of self-insurers -- which gives no indication of the size or exposure of the employers who self-insure -- is the percentage of the losses incurred by self-insured businesses, as shown in Figure III-2. This is a better indicator of the share of workers' compensation business now being self-insured rather than being covered by private insurers.



As the graph depicts, prior to 1991 self-insurance did not cover much more than 20 percent of the workers' compensation market. By 1993, however, this had increased dramatically to almost 30 percent. This declined to about 25 percent in 1994, most likely due to companies purchasing high-deductible policies.

Second Injury Fund Coverage

In addition to covering their workers' compensation liability, employers are also responsible for funding the Second Injury Fund. The fund, which is administered by the State Treasurer's Office, covers claims of workers who suffer a second injury on the job, have a pre-existing condition, or whose employer does not have insurance, as well as other less frequent types of claims.

The Second Injury Fund is based on "pay as you go" and does not reserve for claims payment. Assessments for the Second Injury Fund have been based on an insurance company's or employer's losses. Statutorily, assessments can be up to 5 percent of losses, but the fund can assess as many times as necessary to cover claims against the Fund. For FYs 93, 94, and 95, there have been 3, 2, and 4 annual assessments, respectively.

Employers are allowed statutorily to cover their Second Injury Fund assessments in much the same way as they protect against their general workers' compensation exposure, through private insurance, self-insurance, or a combination of both.

The payment of the SIF assessments is a condition of doing business, and failure to pay the SIF assessments when due, can statutorily result in a denial of the privilege of doing business in Connecticut or to self-insure under workers' compensation.

An employer who is self-insured but who cannot make claim payments mandated under workers' compensation, thereby requiring payment from the Second Injury Fund, is prohibited from self-insuring the company's worker' compensation exposure again for 10 years. Failure to insure full liability shall result in the denial of doing business in the state.

Accident, Health and Life Insurance

Under the law governing workers' compensation statutes in Connecticut (C.G.S. Sec. 31-284b) companies that have provided accident and health insurance or life insurance coverage for their employees, or that provide regular contributions to a welfare plan are required to continue that while the claimant is collecting workers' compensation.

The statute allows the employer to use any of the same methods (e.g., private insurance or self-insurance) allowed for covering general workers' compensation liability.

While there has been no change in Connecticut's law concerning the requirement that employers continue to pay health, accident and/or life insurance, both the Connecticut and U.S. Supreme Courts have found such laws to be unconstitutional (U.S. Supreme Court decision in D.C. vs Washington Board of Trade in 1992 and Connecticut Supreme Court decision in Frank Luis et. al. vs Frito Lay in 1993). In addition, the Attorney General's Office issued an opinion in September 1993 that the Second Injury Fund, which had been paying these benefits to claimants in the fund, no longer had to pay for the continuation of these benefits.

Insurance Rates

Background. The base for all premiums charged in workers' compensation are commonly known as the manual rates. These are the rates represented by the loss costs developed by the National Council on Compensation Insurance and submitted to the state Insurance Department.

These manual rates are the foundation upon which all companies build their final premium, and the manual rates are based upon a large pool of statistical data that are classified by risk or job.

Once the manual rates are established, prices are then allocated into major components -- manufacturing, contracting, goods and services, office and clerical, and miscellaneous -- according to costs (losses) experienced in each of these areas. The costs or pricing are further refined into about 600 job classifications, which are charged different rates depending on the risk of that job. Generally, each place of employment is classified by the highest-risk activity being carried out at the facility. There are exceptions to this, the most frequent being that office and clerical workers are classified differently from the major or governing class.

Based on past experience of each classification, actuaries project losses into the future and establish a rate to charge employers for each job class. The losses generated within a state are used to predict a rate if the pool of data is statistically large enough. If it is not, nationwide data must be added to the base to improve its predictability. But, at least half of the rate must be developed using state loss data. In the 1992 manual rate filing, fewer than one-third of the classes relied totally on Connecticut-specific data.

Once a rate has been established for a particular class, the rate is then multiplied by each $100 of payroll. Prices per $100 of payroll vary dramatically -- for example, railroad construction workers are charged more than $35 for each $100 of payroll, while the rate for clerical workers is $0.36. The manual rates do not include an insurer's operating expenses, which each company must apply individually. Typically, the expenses add an additional 25 to 30 percent to the manual rate to get the full premium.

Because the workers' compensation insurance market is considered a competitive one, individual insurance companies are not locked into charging the rate the rating organization files with the department. In addition to varying its expense component, individual companies have various ways in which to change the rates, including deviations from the manual rate, deductibles, experience modifications, retrospective rating plans, and premium discounts.

For example, an insurance company may deviate from the NCCI rates, if it can demonstrate to the Insurance Department that its loss costs are different from those filed by the rating organization. Also, since 1991, companies have been marketing workers' compensation policies in Connecticut that offer deductibles. In return for sharing some of the risk, the policyholder is charged lower premiums. Mutual companies may also offer their insureds some sort of dividend, also lowering the premium amount.

Experience modifications are mandatory in Connecticut for all insured businesses that pay more than a certain amount in premiums, which requires insurers to modify the employer's premiums depending on that particular policyholder's experience. Also, premium discounts are allowed as are retrospective rating plans, where the policy is written to cover certain expected losses plus an amount to cover expenses.

Approval of rates. The licensed rating organization -- in Connecticut this is NCCI -- is statutorily required to have on file with the insurance commissioner, at least 30 days before its effective date, all classification manuals, rules and rates, minimum class rates, rating plan, rating schedule, and rating system and any modification to the above which it uses. To the extent that individual insurers use these, the rating organization's filings are sufficient. Unless disapproved during the 30 days -- or an extension of 30 days allowed by law with notification to the insurer or rating organization-- the rates go into effect .

The insurance commissioner is required to send notification of disapproval of the filing, specifying in what respects the filing fails to meet statutory requirements, and stating that the filing will not become effective. In practice, the insurance commissioner has always held a public hearing on the workers compensation rate filing from the rating organization before it becomes effective. The most recent rate hearing was held on June 20, 1995.

The rating organization is not allowed to file, compile, or distribute rates or recommendations relating to rates that include profits, general expenses, or brokerage or license fees for the voluntary market. However, individual insurers may have the rating organization file for that company on their behalf, or the individual insurer may produce and file rates for that individual insurer based on the insurer's exposure, loss, expenses, and profit.

Public Acts 91-339 and 93-228

No changes dealing with rates were included in the 1991 act, although another 1991 act, P.A. 91-407, required that the Legislative Program Review and Investigations Committee examine factors related to workers' compensation insurance premiums. (The study was conducted and the report was issued in March 1992.) Rate-related provisions included in Public Act 93-228:

- required insurers or the license rating organization to give employers whose policies expired after July 1, 1993, a rebate of 19 percent on their premiums for the post-July 1, 1993 term;

- allowed insurers, or rating organization, to take into account "due consideration for changes in loss costs based on experience updated through the end of 1992";

- required that, within 30 days after the insurance commissioner makes his final decision regarding the rates filed by the rating organization, each workers' compensation insurer file revised rates that would be applicable for new and renewal policies effective on or after July 1,1993;

- policies in effect on June 30, 1993 -- for the period from July 1, 1993, through the end of the policy period -- would have their premiums reduced by the

percentage that equals the benefit level reduction certified by the independent actuary and the insurance commissioner;

- required insurers, within 45 days after the rates became final, to adjust premiums for new and renewal policies effective on or after July 1, 1993, but before the new rates became final;

- required the insurance commissioner to hold a public hearing on any workers' compensation rate filing made by a rating organization; and

- required the insurance commissioner to consult with an independent actuary for the purpose of certifying the accuracy of the benefit level reduction and also to determine how well the rates measure against the statutory standards -- that they not be excessive, inadequate, or unfairly discriminatory.

Workers' Compensation Premiums

Background. As noted previously, the premiums paid by an employer are based on the employer's total payroll multiplied by the rate for the primary job class of the employer's workforce. Consequently, total premiums generated in Connecticut are based on the total payrolls of all insured employers in the state and the rates applied to those job classes that comprise the state's workforce. Thus, premiums can change due to modifications in payroll, or the rate.

Table III-3 gives examples of how these both impact on premiums. Individual insurance companies may add their own expense portion to the rate, typically about 25 percent, thus, for the rate column in table, a 25 percent expense ratio has been incorporated into the rate. (Of course, as outlined earlier, an individual employer's own experience and other factors also play a role in the rate charged, as outlined earlier, but have not been considered for this table.)

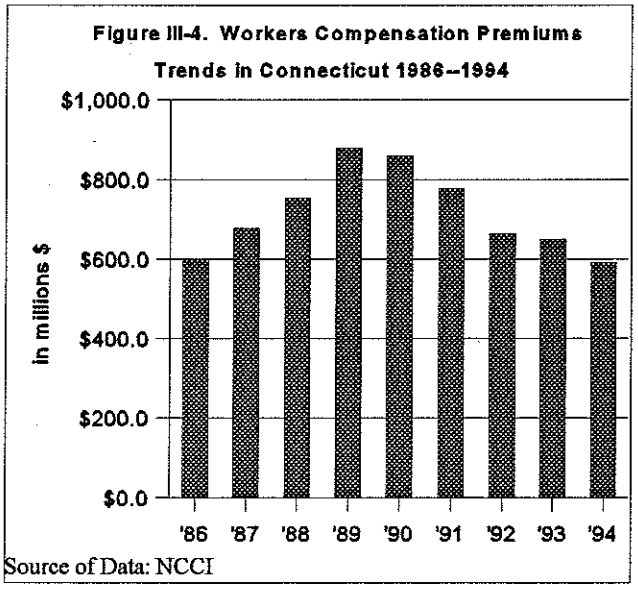
As the table shows, declining payroll can have just as great an impact as decreasing rates on the overall premium, and when both rates and payrolls decline simultaneously -- as with tool manufacturing class in Table III-3 -- premiums decline sharply. These drops in a number of classes can then effect the overall premiums generated in the state.

Of course, premiums are also influenced by factors in addition to the economy and fluctuations in rates. The number of companies that self-insure and the degree (or amounts) those companies self-insure, through high deductibles, can also have a great impact on the premiums generated in workers' compensation. These are all notes of caution that must be considered when examining trends in premiums in a state, or making an interstate comparison, and are especially worth noting here, considering the drop in premiums generated in Connecticut over the past few years.

Table III-3. Examples of Premiums Impacted by Payroll and Rates for 1988, 1992, and 1995			
Example 1: Hypothetical Employer in Clerical Classification			
Payroll		**Rate per $100**	**Total Premium**
1988	$150,000	$.40	$600
1992	$175,000	$.45	$717
1995	$200,000	$.41	$820
Example 2: Hypothetical Employer in Tool Manufacturing			
Payroll		**Rate per $100**	**Total Premium**
1988	$500,000	$4.63	$23,150
1992	$400,000	$4.02	$16,080
1995	$300,000	$3.50	$10,500
Example 3: Hypothetical Employer in Concrete Construction			
Payroll		**Rate per $100**	**Total Premium**
1988	$500,000	$17.81	$89,500
1992	$400,000	$23.00	$92,000
1995	$300,000	$22.00	$66,000
Formula for premiums is Payroll/100 x Rate per $100 = Premium Source: Committee Staff Analysis Using NCCI Rates			

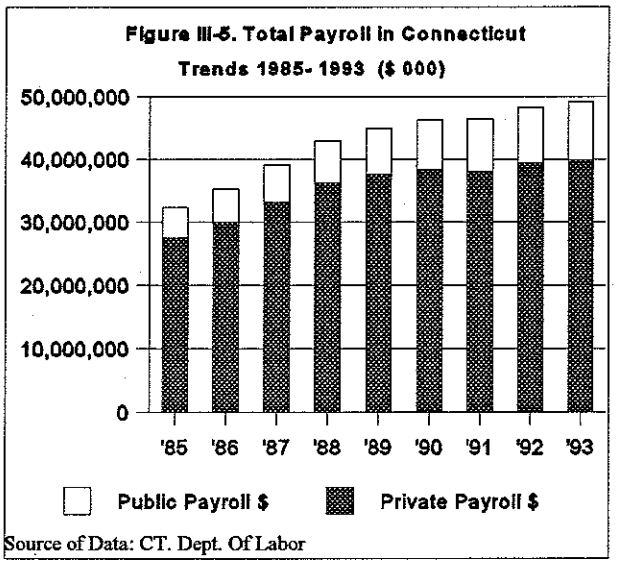
As Figure III-4 shows, premiums for private insurance in Connecticut were at about $600 million in 1986. At their highest point, in 1989, premiums in Connecticut were almost $860 million. By 1994, however, premiums generated through private insurance had declined to the 1986 level of approximately $600 million.

The reasons for the decline in total premiums are not completely clear. Basically, as illustrated in the rate section, overall workers' compensation rates had increased in Connecticut during the period until the legislature mandated the rate reduction in July 1993. Rates declined again in July 1994, and



the NCCI rates filed in June of 1995 call for another drop effective July 1, 1995. These rate decreases no doubt contributed significantly to the drop in premiums. However, as the graph indicates, premiums were already beginning to decline prior to the mandated decreases in rates.

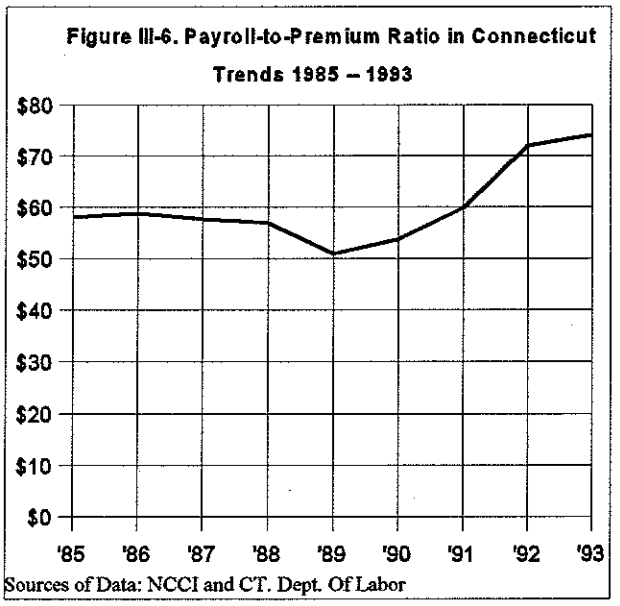
The program review committee examined some plausible reasons for this. First, declining premiums may be somewhat linked to a stagnant payroll in the state. For the most part, total payroll in Connecticut has continued to grow, as shown in Figure III-5, but that total growth has slowed dramatically, especially in the private sector. For example, payroll statistics maintained by the Connecticut Department of Labor show that between 1985 and 1988 total payroll grew from about $32 billion to $42 billion -- a one-third increase in the span of three years. From 1988 to 1993, total payroll increased by another $6 billion, only about a 14 percent increase in a 5-year period.



Further, the private sector payroll -- which would be more closely linked to premiums than public or non-profit payroll -- grew barely at all during that five-year period. In fact, in 1991, payroll for the private sector actually declined by about $300 million, but recovered in 1992 and 1993. Thus, while hard to quantify exactly, there appears to be some link between decreasing premiums and static payrolls in Connecticut.

To further analyze the aspect of premiums related to payroll in Connecticut, the graph in Figure III-6 illustrates a ratio of total state payroll generated to premiums paid. This is the same ratio used earlier in comparing Connecticut's ratio with other states.

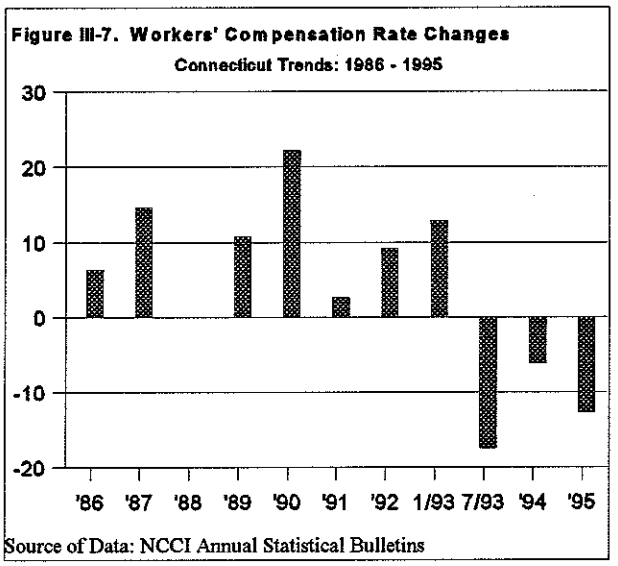
As the graph shows, the payroll-to-premium ratio has increased, meaning that in the aggregate, Connecticut employers are spending less per total payroll in private workers' compensation premiums than they had in the past. In 1989, when premiums were at their highest point, the ratio was $1.00 in premiums for every $50.90 in payroll; by 1993 this had declined to $1.00 paid in premiums to every $74.15 spent on payroll.



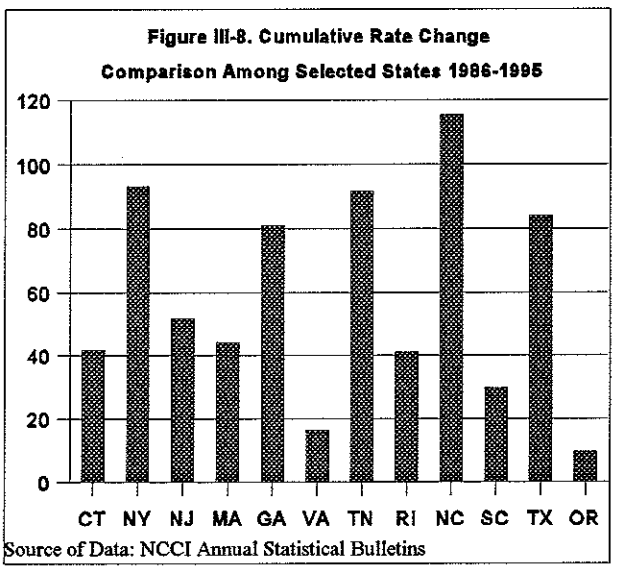
Thus, by almost every measure premiums spent on private insurance have come down since 1989. The two main areas that have probably offset this are the amounts spent on assessments for the Second Injury Fund and the amounts employers are spending through total self-insurance or partial self-insurance through high deductibles.

Analysis of Rate Experience

Rate changes in Connecticut. One of the factors that led to the 1991 and 1993 pieces of reform legislation had been the trend in ever-increasing workers' compensation insurance rates. It had been typical for rates to experience annual double-digit growth. In fact, in 1990 rates grew by 22 percent in that year alone. Figure III-7 shows the year-to-year changes in the workers' compensation rates in Connecticut. To make the years comparable for the trend analysis, the rate change for 1995 (-12.7 percent) shown in the graph does not include the impact of the elimination of the Second Injury Fund. If the fund elimination is considered, the rate change would be a decrease of 4.1 percent from 1994.

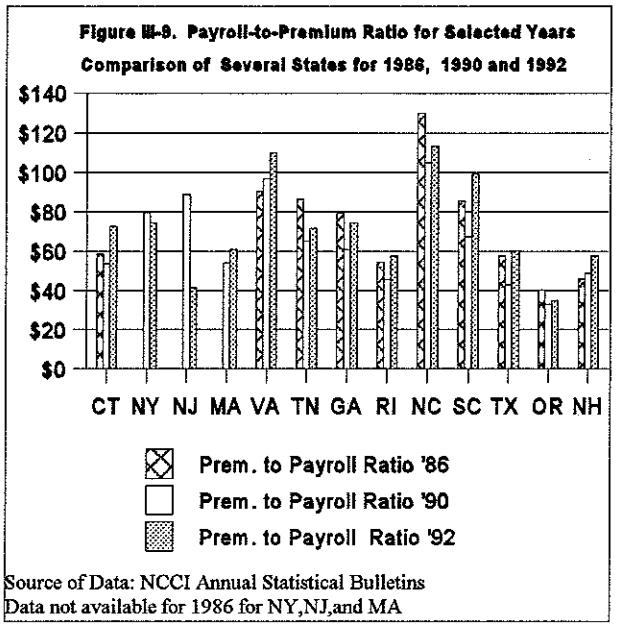


Including the July 1, 1995 filed rates, the cumulative rate changes over the 10-year period have shown a 41.9 percent increase. This includes a 30 percent decrease in rates since 1993. To get a sense of what Connecticut's experience has been relative to other states in terms of workers' compensation rates, the committee compared the cumulative rate increases for the years 1986 to 1995. Connecticut's cumulative rate change experience compares favorably with those of other states, as Figure III-8 shows. Of the 12 states displayed, Connecticut's rate increases were 8th highest.



To gauge Connecticut's experience with workers' compensation rates with those in other states, staff took premiums paid for private insurance in a number of states for three separate years -- 1986, 1990, and 1992 -- and developed a ratio of payroll to premiums for the same respective years for each of those states. The premiums paid do not reflect any types of self-

insurance. The ratio for the different years are shown by the bars in Figure III-9. The payroll-to-premium ratio is an indicator of competitiveness to some degree, since, in overall terms, it indicates how many dollars are generated in payroll to support each dollar paid for insurance premiums. The larger the ratio the better, meaning that state generates X amount in payroll before having to pay $1.00 in workers compensation premiums.



As the graph shows, the states with the most competitive ratios are North Carolina, Virginia, and South Carolina. Further, Connecticut's premium-to-payroll ratio has improved, as indicated by the bar on the right, however, the ratio in Connecticut still lags considerably behind some of the other states.

In addition to improving its position in terms of total payroll generated to premiums paid, Connecticut's rates for individual classes have also improved in comparison to other states. Table III-10 compares the latest effective rates for several classifications -- in the voluntary or competitive market -- for Connecticut as well as several other states being used for comparison. When the program review committee conducted its study in 1990, Connecticut compared unfavorably with neighboring states in most of these classifications. While the table shows that the rates are not the lowest in Connecticut for any of the rates, it does show that for most of the rates Connecticut does appear competitive with neighboring jurisdictions. However, the southern states, especially South Carolina and Virginia have rates that are still considerably lower than Connecticut and the other states.

Thus, the committee's analysis indicates that Connecticut's rate experience in workers' compensation insurance has been improving, and that its rates appear to be becoming more competitive with other states.

Rate Suppression

Rates have been decreasing in Connecticut without the suppression by rate regulators that has occurred in other states. The rates that have been requested in Connecticut have almost always been approved. This has not been the case for most other states examined in this study, where rate approvals have been considerably lower than what gets requested. This phenomenon, known as rate suppression, is analyzed in Table III-11.

Table III-10. Comparison of Latest Effective W.C. Insurance Rates in the Voluntary Market for Selected Job Classes in Selected States													
JOB CLASS	CT Effect. 7/95	RI Effect. 5/92	NH Effect. 1/95	ME Effect. 1/95	NY Effect. 10/94	NJ Effect 1/95	MA Effect. 1/95	NC Effect. 1/94	SC Effect. 1/92	VA Effect. 1/95	GA Effect. 1/91	OR Effect. 1/95	TX Effect. 1/91
Iron/Steelworker	$23.29	$25.26	$12.62	$11.52	$42.86	$14.99	$17.87	$10.16	$6.15	$7.27	$14.95	$7.69	$19.59
Tool Mfg.	$2.87	$3.70	$3.51	$3.94	$4.74	$2.93	$3.50	$3.07	$2.72	$1.19	$4.87	$2.29	$8.10
Metal Goods Mfg.	$4.63	$14.24	$5.51	$6.65	$15.73	$6.48	$8.60	$4.66	$3.54	$3.41	$10.92	$5.07	$16.22
Machine Shop	$3.64	$7.46	$3.45	$4.44	$8.49	$4.34	$4.32	$4.25	$2.62	$2.21	$6.30	$3.33	$12.36
Concrete Construction	$17.50	$19.56	$20.86	$18.82	$24.62	$10.57	$41.94	$11.41	$9.19	$11.29	$13.67	$14.28	$25.59
Carpenter	$19.69	$16.25	$19.00	$29.13	$18.65	$10.41	$30.68	$18.51	$15.02	$8.45	$20.73	$13.61	$28.29
Trucking	$14.22	$14.25	$13.26	$14.88	$17.76	$13.05	$13.55	$13.39	$7.22	$8.30	$14.41	$11.28	$18.38
Store (Wholesale)	$6.38	$6.09	$7.30	$5.39	$8.23	$5.03	$7.67	$4.82	$2.49	$2.42	$6.02	$4.30	$9.24
Clerical	$.33	$.52	$.48	$.69	$.57	$.38	$.30	$.37	$.34	$.19	$.66	$.37	$.64
Hospital -- Professional	$1.14	$2.90	$1.29	$1.79	$2.24	N/A	$1.96	$1.25	$.87	$.81	$1.76	$1.30	$2.44
Hospital Other	$2.29	$5.65	$6.02	$4.62	$8.09	N/A	$6.65	$4.64	$2.11	$1.96	$9.01	$5.29	$15.12

For all states except New Jersey, Rhode Island, Texas, North Carolina, New York, and Massachusetts these rates are for advisory loss costs only, which excludes general expenses, taxes, profit, and assessments. (Typically about 25% is added to the rate by individual companies for these expenses) Most of the states, excluding Oregon, include loss adjustment expenses in their advisory rate. New Hampshire includes loss adjustment expenses and Second Injury Fund assessment in the rates.

Table III-11. ANALYSIS OF WORKERS' COMPENSATION INSURANCE RATE REQUESTS FOR SELECTED STATES

1 State	2 # Rate Change Requests	3 # Approved without Significant Changes **	4 Sum of Rate Changes Requested	5 Sum of Rate Changes Approved	6 Sum of Deviations	7 Deviation per Occurrence	8 Ratio -- % Requested to % Approved	9 % in Assigned Risk --1994
CT (lc)	7	6	30.6	18.9	11.7	1.6	.62	11.4
GA (r)	2	0	26.0	18.6	7.4	3.7	.72	30.7
ME (r/lc)	6	2	50.9	0.8	50.1	8.3	.02	82.4
MA (r)	5	1	69.7	17.0	52.7	10.5	.24	47
NH(r/lc)	6	6	78.5	29.3	49.2	8.2	.37	41.8
NY (r)	7	2	79.3	52.3	27.0	3.8	.66	N/A
NJ (r)	6	5	51.9	45.3	6.6	1.1	.87	26.6
NC (r)	5	2	160.5	86.1	74.4	14.8	.53	23.7
OR (lc)	6	4	-25.7	-36.0	10.3	1.7	.70	8.7
RI (r)	1	1	32.0	32.0	0	0	1.00	88.6
SC (lc)	4	1	13.5	4.1	9.4	2.3	.30	42.7
TN (r)	9	6	104.5	57.5	47	5.2	.55	52.3
TX (r)	2	0	53.7	22.5	31.2	15.6	.42	N/A
VT (r/lc)	7	3	64.7	48.8	15.9	2.2	.75	36.4
VA (r/lc)	4	0	74.5	12.9	61.6	15.4	.17	29.1

** Significant means a change of more than 10 percent in the rate requested and the rate approved

Source: Analysis of NCCI Data

High rate request states -- requests totaling more than 60 percent between 1990 and 1995:MA, NH, NY, NC, TN, VT, and VA **Moderate rate request states** -- requests totaling between 40 and 60 percent between 1990 and 1995: ME, NJ, and TX, **Low rate request states** -- requests totaling less than 40 percent between 1990 and 1995: CT, GA, OR, RI, and SC

High rate approval states -- approved rates totaling more than 50 percent between 1990 and 1995: NY, NC, and TN **Moderate rate approval states** -- approved rates totaling between 20 and 50 percent between1990 and 1995: NH, NJ, RI, TX, and VT **Low rate approval states** --approved rates totaling less than 20 percent between 1990 and 1995: CT, GA, ME, MA, OR, SC, and VA

Large deviations states -- differences totaling more than 50 points between 1990 and 1995: ME, MA, NC, and VA **Moderate deviations states** -- differences totaling totaling between 20 and 50 points between 1990 and 1995: NY, TX, TN and NH **Small deviation states** -- differences totaling less than 20 points between 1990 and 1995: CT, GA, NJ, OR, RI, SC, and VT

The table displays several measures relating to rate requests and approvals between 1990 and 1995 for 15 states including Connecticut. The letter beside each state indicates whether it is a state where the full rate is filed or only loss costs. Maine, New Hampshire, Vermont, and Virginia changed methods during the period analyzed. Column 2 shows the number of rate requests in each state; column 3 shows the number of requests approved that have not had a significant (more than 10 percent) change; column 4 shows the amount of the cumulative rate requests; column 5 shows the sum of the cumulative rate approvals; column 6 shows the sum of the differences between columns 5 and 4; column 7 shows the average deviation per occurrence; column 8 contains the ratio of the percent approved of that requested; and finally column 9 contains the latest available percentage of premiums written in the assigned risk or non-voluntary market.

Connecticut is tied for first place in terms of the number of times a rate request was approved without a significant change, as the results in column 3 indicate. Since 1990, only one of the seven rate requests filed in Connecticut has been significantly changed before approval, and that was in 1990. The data show Connecticut ranks 4th-lowest in terms of the sum of the deviations, which appear in Column 6. This means the total amount of the difference between requested and approved rates was 11.7, suggesting that insurers do very well with their rate filings. Connecticut would rank even lower in terms of the difference between total requested and total approved if Georgia and Rhode Island -- where rating organizations were told no rate increases would even be considered -- were discounted.

However, rate suppression, as exists in other states, does have some negative repercussions. In most states that have experienced rate suppression, the state also has a high percentage of premiums written in the assigned risk pool. For example, Maine has had serious rate suppression; only half the rate amounts requested were approved. But about 83 percent of workers' compensation premiums in that state are written in the assigned risk. Connecticut, on the other hand, has had virtually no rate suppression, and of the states shown has the lowest percentage of business in the high-risk pool. Another negative aspect is that rate suppression lowers insurer profitability, which will be discussed later in this section, sometimes to the point where insurers stop writing workers' compensation insurance, resulting in a further shrinking of the state's competitive market.

Connecticut's Insurance Market and Its Competitiveness

Most employers in Connecticut can obtain workers' compensation insurance in the voluntary market. This means, theoretically at least, that most state businesses should enjoy the elements of a competitive marketplace, including a competitive price, for the coverage they purchase. The following are some indications this is the case:

- Connecticut's rates for workers' compensation are based on loss costs only; individual insurance companies compete to lower the premiums charged through lower expenses. Companies writing workers' compensation in Connecticut do compete on those expenses; while most of the 105 companies who filed to implement the 1994 manual rates had expense multipliers of 25 to 30 percent of

manual rates, some indicated no expense factors, while others were as high as 40 percent;

- Companies in Connecticut may deviate from the loss costs rates filed by the rating organization, if approved by the Insurance Department, and a number of insurers do. Twenty-eight of the same 105 companies filed downward deviations, as much as 20 percent, from the filed rates, while 4 companies had deviations upwards. Some deviations were for particular classifications.

- The state's dividend ratio for workers' compensation insurance, which is current year policyholder dividends divided by the previous year's earned premiums, has been better than the national average for the past three years reported. In 1993, the last year available, the nationwide ratio was 3.8 percent, while in Connecticut, it was 5.2 percent, more than one-third higher.

- Employers can lower their premiums by choosing products other than a standard policy. High deductible policies and retrospective rating plans can significantly reduce premiums to employers. Declining premiums in the workers' compensation market, as discussed earlier in this chapter, indicate that a great number of employers are purchasing these alternative policies.

- Another alternative for large employers who believe they are not getting the most competitive price is to self-insure. More employers are selecting this option -- the number of self-insurers grew from 134 to 157, or 17 percent, between 1991 and 1994. In addition, the workers' compensation business that is self insured, as measured by percent of total losses that are self-insured, has grown to about 25 to 30 percent of all benefits paid.

Reclassification

Another factor closely related to rates and competition is how businesses are classified for rating purposes. Representatives of a labor organization and a business owner testified at the committee's public hearing in September they believed insurers and NCCI used reclassification as a way of maintaining high premiums, especially in the aftermath of mandated rate decreases in 1993.

The committee examined the data available regarding classification and reclassification and found no evidence of any wide scale upward reclassification. The NCCI provided data on the total number of employer site inspections conducted between January and July of 1995. The data indicate there had been 145 inspections during the period, with 68 resulting in the business being placed in a higher-rated class, 61 in a lower-rated class, and 16 incurring no change.

If a business does not agree with its classification (or reclassification), it may file an appeal with the Workers' Compensation Classification and Rating Appeals Board. Prior to 1993 the appeals

board was comprised entirely of insurers, but since 1993 it has added employer members and one member from the state Insurance Department. The committee reviewed the results of the decisions of the appeals that came before the board during 11 meetings held between March 1992 and July 1995, and categorized them in Table III-12.

Table III-12. Results of Appeals Decisions before the Workers' Compensation Classification and Rating Appeals Board -- March 1992 -- July 1995.

Issue	Withdrawn	Continued	Approved	Rejected	Rescheduled/Other
Classification N=60	5	5	21	24	5
Rating/Experience N=9	--	--	3	6	--

Source of Data: Analysis of Appeals Board Meeting Minutes

In addition, the committee asked in its survey of employers in the state whether they had been placed in a different classification since 1993. Thirteen of the 53 employers (24 percent) that responded to the question said that they had been reclassified, but only 7 of the 13 were reclassified upward, while 6 said they were placed in a lower-rated class. This would appear to confirm the NCCI inspection data discussed above, which indicates that about half of the reclassifications are downward.

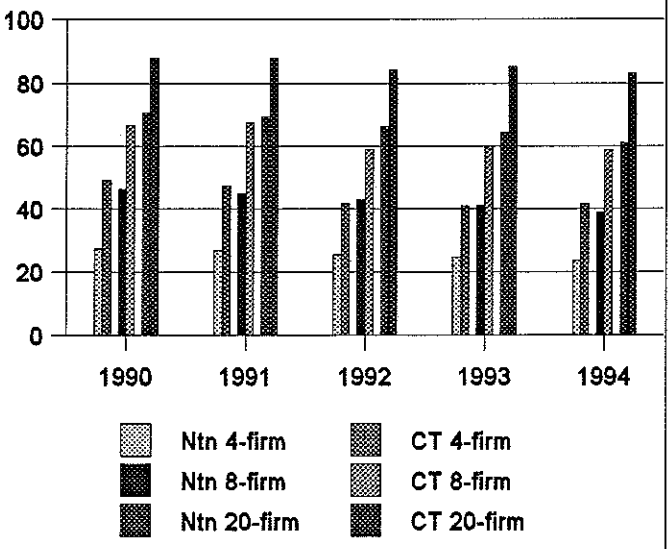
As a result of this analysis, the program review committee finds that reclassification upward is not widespread, that the classifications used to describe work activity are used nationwide and are not unique to Connecticut, and if an employer is unhappy with the classification or reclassification, there is a mechanism for appeals. Further, the appeals are decided in favor of the employer almost as often as against. Thus, the program review committee concluded there is no need for a recommendation in this area.

Market share. The above measures seem to indicate a fairly competitive market for workers' compensation insurance in Connecticut. There are other measures, however, that point to a less than optimal competitive market in Connecticut. As previously noted, there are between 100 and 150 insurers writing more than $500,000 in workers' compensation premiums in Connecticut, certainly enough to ensure an adequately competitive environment. But the top insurers control a greater percentage of market share than the nationwide average, raising a concern about market concentration.

Figure III-13 shows the market share of the top writers by 4-firm, 8-firm, and 20-firm categories in Connecticut and nationwide for the years 1990 to 1994. As the graph indicates, Connecticut has been experiencing less market concentration since 1990, indicating a more competitive market. However, the graph also shows that Connecticut's market remains substantially less competitive than the average of all states' workers' compensation markets.

Another indicator, the Herfindahl index, which is defined as the sum of the squares of each firm's percentage of market share, is used by economists to measure market competition. Based on this measure, Connecticut ranks only 27th of the 50 states in terms of competitiveness.

Figure III-13. Comparison of Market Share by Category of Top Writers Connecticut and Nationwide



Source: NCCI

Comparison of States' Loss Ratios

Another way of comparing the experience in the workers' compensation market in Connecticut is to contrast the percentage of losses for claims paid from the premiums generated. Premiums collected are expected to more than cover any losses that will be incurred during the period of time that those policies cover. One of the key factors in maintaining solvent insurance companies is to ensure the rates charged generate enough premiums to cover losses, and is one of the areas examined by the Insurance Department when approving rates. Table III-14 shows Connecticut's loss ratios -- which is the percentage of the premiums collected that pay for claims -- from 1988 to 1994, and compares them with those of other states that have been used for comparative purposes for this review.

Two items are worthy of note from Table III-14. First, nationwide workers' compensation loss ratios have been declining fairly substantially -- about 25 percentage points -- between 1988 and 1994, indicating better experience in workers' compensation insurance nationwide. Second, Connecticut's loss ratio has almost always been in the lower half of the 14 states examined for comparison purposes, and, with the exception of 1992, has always had a lower loss ratio than the national average.

Table III-14. Comparison of Loss Ratios by State							
State	**1988**	**1989**	**1990**	**1991**	**1992**	**1993**	**1994**
CT	***81.7***	***79.3***	***80.1***	***82.7***	***94.4***	***72***	***53***
GA	92.9	90.5	84	84.1	81.2	69.5	51.9
ME	144.0	154.7	143.7	186.4	98.9	80.7	82.5
MA	110.9	101.9	109	109.1	69.9	55.8	50.6
NH	79.8	86.4	93.5	111.2	103.4	84.3	46.7
NJ	74.5	74.4	92.5	96.9	102.4	90.4	75.5
NY	78.6	78.6	81.4	85.2	96.3	41.6	78.1
NC	91.3	87.4	102.5	98.4	91.6	86.6	59.0
RI	131.3	130.2	143.4	127.7	73.3	51.7	65.6
SC	75.7	81.7	80.4	72.6	58.4	62.9	55.1
TN	91.4	92.1	89.1	85.7	84.2	73.9	66.5
TX	109.6	104.5	94.7	79.5	71.5	62.1	39.1
OR	102.7	96	66.2	65.5	41.5	88.3	71.2
VA	79.2	86	87.1	98	89.6	84.2	71.3
NTL	***86***	***86***	***85.2***	***85.9***	***83.1***	***73***	***60.8***
Source of Data: National Association of Insurance Commissioners							

Comparison of Profitability with Other States

A final measure of the workers' compensation insurance premium component is how profitable the workers' compensation line of insurance is in Connecticut compared to other states. The objective of regulating rates is to ensure a balance between rates that support enough profits to keep companies writing the line of insurance, and to foster a competitive environment where businesses can obtain workers' compensation insurance in the voluntary market but not make unreasonable high profits. Of course, what is "reasonable" profit is always a subjective measure.

While a certain level of profitability indicates a healthy commercial environment, too high a level of profitability, especially in a market like workers' compensation, where the purchasers are mandated to buy the product, is viewed with some suspicion.

In Connecticut, workers' compensation insurers have generally enjoyed a higher level of profits than has been the case nationwide. Table III-15 shows Connecticut's profitability levels

during the period 1988 through 1994. The profitability statistic presented in the table measures "total profitability", which is used by the National Association of Insurance Commissioners (NAIC) to gauge profits as a percentage of direct premiums written for that year after losses and other expenses, including taxes, are subtracted, but including investment gain.

Table III-15. Comparison of Profitability in Workers Compensation Insurance by State

State	1988	1989	1990	1991	1992	1993	1994	Avg. 88-94
CT	***-2.5***	***7.7***	***9.5***	***9.8***	***6.0***	***19.0***	***32.2***	***11.7***
GA	-8.9	0.3	4.8	5.6	7.6	16.4	24.3	7.1
ME	-46.5	-36.3	16.7	-46.9	25.3	38.9	23.7	-3.5
MA	-24.1	-5.9	-8.9	-7.7	25.4	32.5	31.6	6.1
NH	1.3	3.2	0.7	-10.2	0.6	12.0	35.5	6.1
NJ	0.2	10.3	0.7	-0.5	-1.8	7.4	11.6	3.9
NY	-0.5	13.0	1.0	4.6	1.3	7.0	9.1	5
NC	-8.4	1.8	12.9	-4.6	4.4	14.9	21.7	6.1
RI	-16.6	-22.2	-26.8	-7.3	31.8	43.3	27.0	4.1
SC	3.8	4.5	5.7	13.5	21.7	15.2	18.7	11.8
TN	-7.9	-2.0	-0.1	3.2	4.9	13.0	13.3	3.4
TX	-20.7	-11.2	-4.8	6.1	19.3	26.5	36.6	7.4
OR	-15.7	2.4	31.5	28.4	45.5	15.5	22.1	18.5
VA	0.1	3.4	4.9	0.6	10.4	12.0	15.1	6.6
NTL	*-5.9*	*2.9*	*4.4*	*4.6*	*9.4*	*15.4*	*18.3*	*7*

Source of Data: National Association of Insurance Commissioners, Annual Reports on Profitability

As the table indicates, Connecticut's profit level has been higher than most other states, and the national average. Profit levels in this state averaged 11.7 percent over the last 7 years, while nationwide they have been 7 percent. Certainly, the states that had severely suppressed rates during the late 1980s and early 1990s significantly strangled profits and brought down the national profitability average. While the program review committee believes that in the past profit levels in Connecticut were reasonable, the 1993 and 1994 levels appear excessive.

This phenomenon of excessive profits following a period of workers' compensation reform is not unique to Connecticut. A similar rise in profitability is observed in other states where major reforms took place, like Oregon, Texas, and Maine. Undoubtedly, this is partly related to the fact

that prices typically do not fall as rapidly as they rise. The committee does not advocate that Connecticut immediately intervene in the market to suppress rates, but recognizes that these profits cannot be tolerated for long.

However, the state should pursue other policies to ensure that Connecticut employers are given an opportunity to cover their workers' compensation claims in the most competitive manner yet ensuring that workers are protected. Specifically, the program review committee considered three options: 1) a state competitive fund; 2) a consumer rate counsel or ombudsmen connected with the state Insurance Department; and 3) lowering the criteria the Insurance Department uses for group self-insurers in order to foster expansion of group self-insurance. However, the committee believes that there are significant drawbacks to the first two options.

Certainly, a state fund can provide an alternative to private insurance, but often the worst risks end up in the state-sponsored fund and the rates charged by that fund have to be as high as, if not higher, than those charged by private insurers. At a time in Connecticut when the legislature has just chosen to virtually eliminate its Second Injury Fund, because of uncontrollable growth, it would seem poor policy and poor timing to recommend such a proposal.

Secondly, the insurance market is not a monopoly, where the buyer is forced to purchase from only one seller, as with a utility or water company. In that type of market, consumer interests need to be protected and an advocate role is appropriate. However, as previously noted, purchasers of insurance do have a choice of companies in the marketplace. In addition, purchasers of workers' compensation insurance are given an opportunity to comment on proposed rates before they are approved. Public hearings are held by the Insurance Department to solicit comments and concerns on the proposed rates before it takes action, and employers have used these hearings as a vehicle to voice their displeasure with rate increases. Certainly, employers also have the option of contracting for their own actuarial review of the proposed rate filing. This seems preferable to creating a new layer of bureaucracy attached to the Insurance Department.

While the program review committee does not believe a consumer counsel or ombudsmen is needed, the committee does believe the Insurance Department regulatory staff who examine workers' compensation needs to be vigilant about ensuring that the proposed rates are measured against the standards for excessive rates. While statutorily the standards are fairly broad and somewhat subjective: " a rate cannot be considered excessive unless 1) such rate is unreasonably high for the insurance provided or 2) a reasonable degree of competition does not exist in the area with respect to the classification to which such a rate is applicable", the statute also states that consideration be given " . . . to a reasonable margin for underwriting profit, . . . to investment income earned or realized by insurers both from their unearned premium and loss reserve fund." That consideration must include the profitability results for workers compensation writers in Connecticut as reported by NAIC and discussed above.

The program review committee believes that a better way to promote competition is to allow more employers to self-insure. Currently, those individual employers who self-insure must receive

a certificate of approval form the Workers' Compensation Commission to cover their liability. In addition, the statute allows employers of similar risk classification to join together to form a self-insurance group, if approved by the Insurance Department.

However, the current criteria that the Insurance Department has established for group self-insurance are very restrictive, and to date the Insurance Department has approved only two group self-insurers. The table on the following page displays the criteria that group self-insurers must meet in Connecticut compared with those in other states. As the data in the table show, Connecticut is by far the most restrictive state on the list, especially concerning the capital requirements.

The National Association of Insurance Commissioners in 1993 issued a set of model regulations concerning requirements for workers' compensation group self-insurance. The monetary limits contained in that model act are substantially lower than Connecticut's requirements. For example, the annual standard premium required in the model regulations is $500,000 while Connecticut's is $3,000,000.

The NAIC is a nationally recognized organization designed to support state insurance departments and commissioners in the regulation of insurance. The NAIC would have no interest in issuing model regulations that would undermine the protection of those insured by group self-insurance. If such an organization issues these standards as acceptable, the program review committee believes it would be in the public interest to adopt them.

The regulations are comprehensive and cover such requirements as: a board of trustees to oversee the group; reporting requirements including financial statements; bonding requirements; examinations by the insurance department; and monetary penalties for non-compliance. The committee believes the regulations afford Connecticut adequate protection.

More realistic criteria for group self-insurance would provide a viable option for employers engaged in the same or similar type of business to form a group for insuring their workers' compensation risks, if they were unhappy with the private insurance market. Certainly, large employers have had the option to self-insure for some time, and are using it with greater frequency. Smaller employers must be given the opportunity to choose something other than private insurance, yet still ensure that their employees are protected if a workplace accident or injury occurs. Thus, the program review committee recommends that:

the Connecticut Insurance Department adopt the National Association of Insurance Commissioners model regulations for Private Employer Workers' Compensation Group Self-Insurance Model Act. Further, the program review committee recommends that monetary criteria for approval be set at the same limits as contained in the model regulations.

Table III-16. Group Self Insurance Minimum Requirements: A State Comparison						
State	**Min. Employees**	**Min. Employers**	**Bond or Letter. of Credit (LOC) Required**	**Bond or LOC $ Amt (000)**	**Min. Working Capital (000)**	**Minimum Premium (000)**
AL	N/A	2 or more	yes	$200	N/A	$1,000
AK	N/A	2 or more	yes	$200	normal claims	N/A
CT	1,000	To be determined	yes	TBD	$1,000	$3,000
FL	N/A	2 or more	yes	TBD	N/A	$500
GA	1,000	10	yes	35% of net anticipated premium	TBD	$300
KS	N/A	2 or more	no	N/A	N/A	$250
KY	N/A	2 or more	yes	$250	N/A	$100
ME	N/A	N/A	yes	TBD	N/A	$100
MA	N/A	5	yes	$100 or 10% of NAP	N/A	$250
MS	N/A	2 or more	yes	tied to special ins	N/A	N/A
MO	N/A	2 or more	yes	$250	N/A	$350
MT	200	2 or more	yes	TBD	N/A	N/A
NH	N/A	2 or more	yes	2 x average annual losses	N/A	$250
NY	N/A	6-10	yes	TBD	40% of exp. Loss	$500
NC	N/A	2 or more	yes	$600	N/A	$1,000
PA	N/A	5	yes	TBD	N/A	$500
RI	N/A	2 or more	yes	$100	TBD	$250
SC	N/A	2 or more of similar size	yes	$50 or 145% of annual avg losses	TBD	$1,000
VA	N/A	2 or more	yes	$250	N/A	$350
Source of Data: National Association of Insurance, Model Regulations Service						

CHAPTER IV

INDEMNITY BENEFITS

Background

As previously noted, employees disabled by work-related injures or illnesses are entitled to medical benefits and payments to replace lost wages (indemnity benefits). In terms of monetary value the compensation benefits distributed under the medical and indemnity categories grew dramatically between the mid-1980s and the early-1990s (see Chapter I, Figure I-3). According to NCCI, indemnity payments currently account for about 47 percent of workers' compensation benefit costs, with the remaining 53 percent attributable to medical payments. The two benefit categories will be analyzed separately. This chapter will deal with indemnity benefits, and medical benefits will be discussed in Chapter V.

The amount and duration of indemnity payments vary depending on the degree (total or partial) and nature (permanent or temporary) of the worker's injury or illness, and his or her wage level. The major types of indemnity benefits available to workers are identified in Table IV-1.

TABLE IV-1. MAJOR INDEMNITY BENEFIT CATEGORIES

Category	Benefit	Duration
Temporary Total (TT)	Wage replacement	From third day of disability to point claimant is able to return to work, if disability lasts more than 7 days, benefits are retroactive to first day
Permanent Total (PT)	Wage replacement	No limit
Temporary Partial (TP)	Wage replacement based on the difference between a claimant's pre injury or illness earnings and earnings while temporarily partially disabled	Continues until partial disability ends or the maximum number of weeks specified in statute for the particular body part or function is reached
Permanent Partial (PP)	Compensation awarded when there remains a permanent loss of a body part or function at the point of maximum medical improvement	Varies based on a statutory schedule that delineates the weeks of compensation to be paid for the loss of that body part or function
Death	Wage replacement	Paid to a spouse for his or her lifetime or until remarriage
Disfigurement/Scarring	Compensation awarded for a permanent and significant scar	One-time payment
Partial disability wage differential (308 and 308a benefits)	Wage replacement awarded at the discretion of a commissioner based on the difference between pre-injury or illness earnings and potential earnings	Paid up to 780 weeks, but could be extended indefinitely at the discretion of the commissioner

State statutes specify formulas for calculating the amount of benefits that a claimant may receive under each indemnity category. Essentially, the formulas involve two components -- one consists of a compensation rate and the other deals with the duration over which benefits will be paid. At the root of the calculation of the compensation rate is a claimant's earnings before the onset of his or her injury or illness. Prior to the 1991 and 1993 reforms, a claimant's compensation rate was two-thirds of his or her average weekly income in the six months preceding the injury or illness. Expressed as an equation:

COMPENSATION RATE = GROSS EARNINGS IN THE 26 WEEKS PRECEDING THE INJURY OR ILLNESS / 26) X .667

By statute, the maximum rate could not exceed 150 percent of the average production workers' wage, and the minimum had to be at least 20 percent of the maximum, but could not be more than 80 percent of the claimant's average weekly.

Prior to the 1991 and 1993 reforms, a claimant's weekly compensation rate was subject to an annual cost-of-living adjustment on October 1 of each year. Also added to the claimant's computed weekly rate was $10 for each dependent child, provided the allowance did not exceed either 50 percent of the total benefit or 75 percent of the claimant's average weekly wage.

The second major component of the formulas used to calculate benefits is the number of weeks of payments that are allowed under each indemnity category. In general, this durational factor is unlimited for the categories involving a total disability, but limited for the various partial disability classes. For example, a totally disabled worker can receive a weekly benefit for the entire period in which he or she is unable to work, but a partially disabled worker can receive benefits only for the maximum amount of time specified for the affected body part or function.

The claimant's derived compensation rate and relevant duration factor are then inserted into formulas that yield the total amount of compensation allowable under each indemnity category. The basic formulas for calculating such benefits are listed below:

TT = (compensation rate) X (# weeks out of work)

PT = (compensation rate) X (duration of life in weeks)

PP = (compensation rate) X (# weeks specified in statute for the affected body part or function, with a partial loss dealt with on a proportional basis)

TP = (percentage of the net difference between a claimant's pre- and post-injury or illness wage rate) X (duration of the condition in weeks, up to statutory limit specified for the affected body part or function)

308a = (percentage of the net difference between a claimant's pre- and post-injury or illness wage rate) X (# weeks specified by the commissioner)

Death = burial allowance plus [(compensation rate) X (# weeks spouse and dependents meet eligibility criteria)]

Disfigurement = (compensation rate) X (# of weeks specified by the compensation commissioner)

Public Acts 91-339 and 93-228

The 1991 and 1993 reform efforts aimed at reducing the cost of the state's workers' compensation system resulted in significant alterations in the state's laws governing indemnity benefits. Although the goal of the indemnity changes in both the 1991 and 1993 public acts was the same -- to cut costs -- the focus was slightly different. Public Act 91-339 sought to cut costs primarily by reducing a claimant's weekly compensation rate, which, as noted above, is one of the two components used in determining the amount of indemnity benefits that will be paid. The second component, duration, was the focus of the cost-cutting strategy employed under Public Act 93-228.

It should be noted that the indemnity provisions in P.A. 91-339 and 93-228 were not limited exclusively to changes in the rate or duration components of the formulas. The two acts also included changes in what was covered or considered a compensable claim under the state's workers' compensation law. Public Acts 91-339 and 93-228 both added restrictions as to compensability under the disfigurement and scarring category. In addition, P.A. 93-288 eliminated compensation for mental and emotional injuries that did not arise out of a physical injury or illness. This act also eliminated benefits for injuries that occur as a result of an employee's participation in social and recreational activities supported by his or her employer, or those resulting from alcohol or drug use.

A summary of the major changes in the indemnity provisions of the two acts is presented in Table IV-2. The table separates the provisions into compensation rate, duration, and coverage issues.

TABLE IV-2. CHANGES IN THE INDEMNITY BENEFIT PROVISIONS		
Pre 1991	**PA 91-339**	**PA 93-228**
COMPENSATION RATE		
Base two-thirds of average weekly gross wage in the 26 weeks before the injury or illness	Changed the base to 80% of net wages (gross wages - federal taxes - FICA) in the 26 weeks before injury or illness	Changed the base to 75% net wages (gross wages - federal taxes - FICA - state income taxed) and increased the number of weeks used to calculate the average to the 52 weeks before injury or illness
Maximum rate total 150% of the state average weekly production wage	No change	Changed the maximum rate to 100% of the state average weekly wage
Maximum permanent partial 150% of the state average weekly production wage	Changed the maximum rate for PP to 100% of the state's average production wage	No change
Cost-of-living adjustment (COLA) Annual increase equal to the dollar amount of the increase in the state's production wage	Changed the COLA from a fixed dollar amount to a percentage equal to the percentage increase in the state's production wage	Abolished the COLA for future claimants
Dependency allowance Added $10 to the compensation rate for each dependent child	Abolished the dependency allowance	No change
Partial disability wage differential (308 and 308a benefits) Rate equals two-thirds of the net difference between pre-injury or illness earnings and claimant's new potential earnings	Reduces the rate to 80% of the net difference between pre-injury or illness earnings and potential earnings	Reduces the rate to 75% of the net difference between pre-injury or illness earnings and potential earnings

Pre 1991	PA 91-339	PA 93-228
	DURATION	
Permanent Partial Statutes list the maximum number of weeks of compensation that may be awarded for certain body parts and functions (called scheduled) and gave commissioners discretion to award up to 780 weeks for loss of body parts or functions not specified in the law (unscheduled)	No change	Created a statutory schedule for all unscheduled injuries and reduced by 1/3 the number of weeks for all scheduled injuries except the back (reduced 28%) and knee (35%)
Partial disability wage differential (308 and 308a benefits) Wage differential benefits of up to a maximum of 780 weeks awarded at the discretion of a commissioner	No change	Reduced the maximum wage differential duration to 520 weeks or an amount equal to the claimant's permanent partial award, whichever is less
	COVERAGE	
Disfigurement/Scarring Payment (comp. rate X no. weeks awarded by a commissioner's judgement) for any permanent and significant scar or disfigurement	Defined terms scar and disfigurement; clarified criteria for making an award (size, visibility, changes in tone texture, or symmetry); and introduced a one-year delay in making an award	Restricted awards to permanent scars or disfigurements on the face, head or neck; or any body part that handicaps a claimant in obtaining or continuing work
Mental and emotional claims Compensable if found to arise out of and in the course of employment	No change	Restricted compensability to disorders that directly arise out of a compensable injury or illness
Social and recreational claims Compensable if injury received during an activity on the employer's premises, or the employer financially supported or derived benefit from the activity	No change	Eliminates compensability for injuries received during voluntary participation in activities primarily social or recreational in nature
Injuries involving alcohol or drugs Compensable unless caused by habitual use of alcohol or drugs	No change	Eliminates compensability for all injuries caused by alcohol or drug use by the claimant

Analysis of Indemnity Benefits

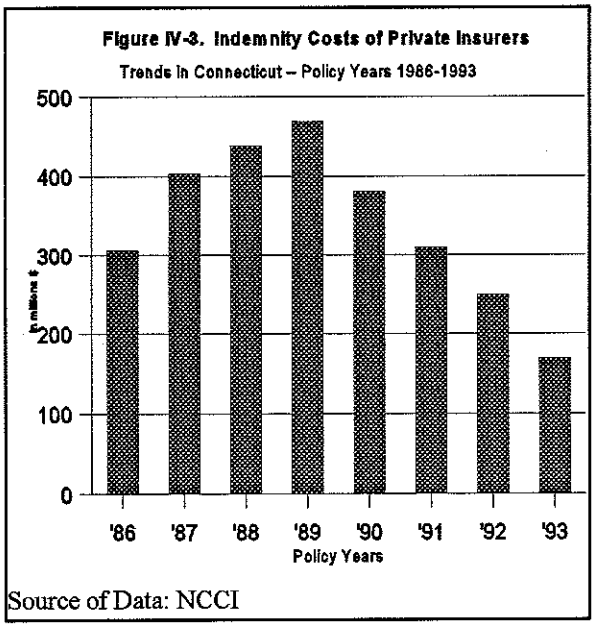
As previously noted, the primary intent of the indemnity benefit changes introduced by P.A. 91-339 and P.A. 93-228 was to reduce the cost of workers' compensation for state businesses. The

assessment of the effectiveness of achieving this goal is limited at this point due to the lag time involved in obtaining data covering the post-reform period. However, data from the National Council on Compensation Insurance can be used to make some preliminary estimates of the impact.

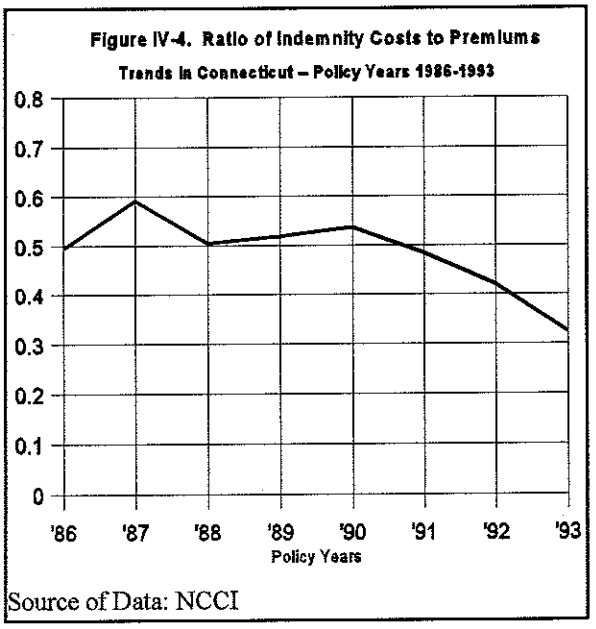
NCCI's 1992 rate filing indicated the indemnity benefit provisions contained in P.A. 91-339 restrained the council's overall rate request to a 9.9 percent increase -- 4.3 percent less than it would have been if the 1991 reforms had not taken place. NCCI's analysis of drafts of the indemnity benefit changes ultimately included in the 1993 legislation supported the 19 percent reduction in insurance rates that was mandated in the final bill.

Figure IV-3 presents NCCI's projected indemnity benefits costs for policy years 1986 through 1993. However, the sharp decline in indemnity costs shown in Figure IV-3 must be viewed with a great deal of caution. The data pictured in the graph represent only the private insurance market and exclude losses experienced by self-insured companies and businesses insuring with high deductibles. Thus, a portion of the decline in indemnity costs shown in Figure IV-3 is the result of the growing number of companies leaving the private insurance market for high deductible policies or totally self-insuring. Predictably, if you collect substantially less in premiums, total costs should also decline.

In an attempt to determine if there are factors other than those related to the changes in the private insurance market involved in the decline shown in Figure IV-3, the committee calculated the ratio of premiums (a proxy for insurance coverage) to indemnity costs. The downward slope of the ratio, which is plotted in Figure IV-4, shows that since 1990 indemnity costs as a percentage of premiums have steadily decreased.



Source of Data: NCCI



Source of Data: NCCI

In financial terms, NCCI estimates that when all the data are reported, $0.59 out of every 1990 premium dollar will be used to pay for indemnity benefits as compared to $0.32 out of every 1993 premium dollar. The fact that a smaller portion of each year's premium dollar is needed to support indemnity benefit costs indicates that the decline in total indemnity costs estimated by NCCI is related to factors beyond the changes in the private insurance market previously noted.

It is important to note that virtually none of the impact of the 1993 reforms is included in the underlying data used to construct the ratios that are shown in Figures IV-3 and IV-4. Other than the mandated 19 percent reduction in premiums in P.A. 93-228, the effects of the 1993 reforms will not begin to appear in the workers' compensation experience until the data for 1994 and beyond are reported. As a result, the committee's findings note that:

- *after rising significantly from the mid-1980s through 1991, the monetary value of the benefits paid under the state's workers' compensation laws has leveled off and has actually shown a slight drop in 1994, the last year for which complete data are available; and*

- *at the point the 1993 reforms were being implemented the trend in the percentage of private insurance premiums collected that were needed to pay indemnity benefits (wage replacement) to injured workers was declining.*

Comparison Among Selected States

A major purpose of reducing workers' compensation costs was to improve the competitiveness of the state's businesses. To judge the relative success of this effort the committee compared Connecticut to selected other states on a few key measures. Included in the comparison were other northeastern states, states competing with Connecticut in the manufacturing area, and two states that have undertaken their own reforms (Oregon and Texas). The comparative measures were: the maximum weekly benefits as an indicator of potential compensation rates; the maximum number of weeks allowed for a nonscheduled permanent partial disability as a proxy for duration; and the cost-per-covered worker. The last statistic is a global indicator used by the National Foundation for Unemployment Compensation and Workers' Compensation to compare states on the total benefits paid annually per covered worker.

The results of the comparisons are shown in Table IV-5. The data indicate that even though the state reduced its maximum weekly benefit by 13 percent in 1993, cut its maximum duration for a permanent partial award by one-third, and held the increase in cost per covered worker to 1 percent, the state still ranked at or near the top among the selected states on key measures. In light of stabilizing benefit payments, but continued high rankings on key state comparison measures, the program review committee concluded that:

- *the benefit structure instituted by the 1991 and 1993 reforms should be maintained.*

Table IV-5. State Comparisons on Selected Workers' Compensation Measures						
STATE	**Maximum weekly benefit '94**	**Rank**	**Non-scheduled Permanent Partial (# weeks)**	**Rank**	**Cost-per-covered worker '93**	**Rank**
RI	$463	6	duration	1	$587	3
MA	$563	2	260 weeks	10	$442	5
CT	***$628***	***1***	***520 weeks***	***4***	***$625***	***2***
ME	$441	9	260 weeks	10	$718	1
NY	$400	11	duration	1	$374	8
NJ	$460	7	600 weeks	3	$319	9
VA	$451	8	500 weeks	5	$209	13
GA	$250	13	NA	NA	$389	7
NC	$466	4	300 weeks	9	$242	12
SC	$410	10	340 weeks	8	$283	11
TN	$356	12	400 weeks	7	$302	10
OR	$479	3	NA	NA	$402	6
TX	$464	4	401 weeks	6	$452	4

Source of Data: AFL-CIO 1994 Report: Workers' Compensation and Unemployment Insurance under State Laws
National Foundation for Unemployment Compensation

CHAPTER V

MEDICAL BENEFITS

Background

The health care delivery system has changed dramatically since workers' compensation was first created. Third-party payers and cost containment measures now dominate the health care system, and medical treatment in workers' compensation is much disputed and litigated, especially since medical opinion most often forms the basis for determining a significant portion of the cost of a claim. Despite the changes over time, the workers' compensation system has always been responsible for payment of medical costs incurred as a result of a work-related injury or disease. There are no limits on the maximum medical cost, nor is there a limit on duration of medical treatment, as long as the treatment is not considered maintenance.

In 1990, when the Legislative Program Review and Investigations Committee conducted its study of the Workers' Compensation Commission, the medical costs in workers' compensation were growing dramatically, especially when compared to the growth in costs on the wage loss side. For example, between policy years 1981-1982 and 1985-1986, Connecticut's average cost per case grew by 71.8 percent in the medical area, while costs on the wage replacement side grew by 40.2 percent.

In its 1990 study the committee found there had historically been little effort to contain medical costs. For example, while the Workers' Compensation Commission had the statutory authority to set a medical fee schedule, and to establish a list of providers permitted to treat workers' compensation claimants, the commission had never exercised either option. The statute did (and does now) require that the medical fees be usual and customary for similar treatment delivered outside of workers' compensation.

At the time of the 1990 study, some insurers were beginning to compare medical costs and fees in workers compensation with other health coverage, and question instances where expenses were substantially different. While medical costs, as a percentage of the average case costs, were then lower than in most other states, that was viewed to be more a function of the high wage replacement costs in Connecticut than lower medical expenses.

Public Acts 91-339 and 93-228

In 1991, Connecticut was one of about 30 states that allowed complete employee choice of medical provider. To deal with the rapidly increasing medical costs, the legislature introduced in its 1991 reform a version of managed care for workers' compensation medical care. The requirements of that managed care program are shown in Table V-1.

Table V-1. Medical Components of P.A. 91-339	
Legislated Change	**Implementation Status**
Allowed employers, or insurers on their behalf, to establish a managed care plan to treat job-related injuries and illnesses for employees receiving workers' compensation. This section became effective on January 1, 1992.	The act required that standards be developed on which to base approval of these plans, The WCC opted to adopt regulations, but they did not become effective until March 1993. Since that time, 42 generic or broad-based managed care plans have been approved. About 1,400 employer applications have been approved covering approximately 180,000 employees. The vast majority of these employers are using or modifying the generic or network plans.
Required that the plans must be approved by the chairman of the Workers Compensation Commission before they could be implemented, and must be submitted at least 120 days prior to their effective date.	Because the regulations did not become effective until March 1993, most of the plans were not approved until 1994 or 1995.
Required that plans be approved every two years	The vast majority of the plans have not been in effect long enough to be up for renewal
Required the chairman, along with the medical advisory panel, to develop standards for what plans should contain in order to be approved	Regulations incorporating such standards were developed and approved. However, they did not take effect until March 1993, almost two years after the law permitting medical managed care plans was passed.
Required that the standards developed must include but not be limited to evaluating the plans for: 1) providing required medical services in a way that's timely, effective, and convenient for employees; 2) including all categories of providers and sufficient number in each category in accessible locations to ensure employees have adequate choice; 3) providing appropriate financial incentives to reduce costs and utilization without reducing service quality; 4) including fee screening, peer review, utilization review, and dispute resolution procedures designed to prevent inappropriate or excessive treatment; and 5) including a mechanism for providing the chairman with sufficient cost and utilization information to evaluate the plan's effectiveness.	WCC staff maps out a radius for each applicant employer to ensure that network providers are located within a 25-mile radius of the employer. Initially, the law had allowed employees to go outside the network as long as the employer did not have to pay more than the plan would pay. The regulations had used this requirement as an opportunity to compare the costs for those claimants who stayed in the network with those who went outside the plan. However, the 1993 legislation prohibited employees from going outside the plan, rendering the requirement for data collection and reporting from the two systems moot. The WCC chairman and medical plan review staff are currently reviewing what data could be collected that will answer cost and utilization questions.

As the status column in Table V-1 indicates, many of the medical components legislated were dependent on regulations being produced. These regulations were developed by the chairman of the commission, in cooperation with the Medical Advisory Board. The regulations became effective March 25, 1993.

The regulations are about seven pages long and require submission of comprehensive information about each proposed plan, including the business or corporation status of the organization, its ability to do business in Connecticut, the identity of its principal owners, the relationship with any predecessor or related organizations, and a report of any sanctions or disciplinary actions taken against the company in any other state.

The regulations also require a description of financial arrangements between the employers and the managed care plan, and between the plan and its providers, as well the information about the responsibilities of the parties, including the employees, in the plan. The regulations also require that there be a minimum of 5 providers in each of 24 categories of medicine, that the list be updated quarterly, and that the selection and removal criteria be submitted as part of the plan. The regulations further indicate that just because a provider meets the criteria he or she does not have to be accepted under the plan.

The regulations require a description of the plan's utilization review and dispute resolution procedures, and set forth minimum requirements for what those should include. Also required is a copy of information distributed to employees about the plan and services available to them, as well as how to obtain them. The regulations prohibit the plan from conflicting with any collective bargaining agreement, and indicate that the employer may be requested to provide a statement to that effect.

Regulations state that plans that do not provide all of the required medical services may be approved by the chairman if such services are available from other authorized practitioners in the state. The regulations require that all utilization review and dispute resolution procedures concerning medical treatment be exhausted before the Workers' Compensation Commission becomes involved in such matters. The regulations contain reporting requirements that include: submission of quarterly reports to the chairman describing the number and results of appeals pursuant to utilization review, dispute resolution review, and appeals procedures. They also require annual reports that compare data of employees treated under medical plans and those treated outside, although this cannot be done now that the law requires employees to see medical providers inside the plan if the employer has one approved.

Finally, the regulations allow the use of staff of the employer or others as care managers or coordinators to assist injured employees in getting appropriate medical services, monitoring employee's progress, and as a communication link between the parties to the plan.

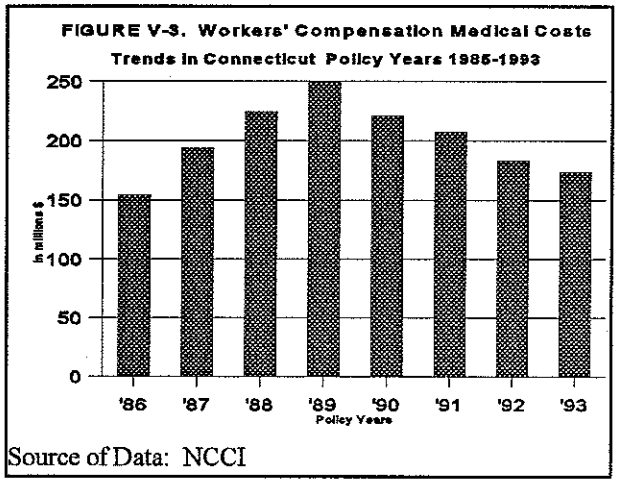
Despite the fact that none of the medical reforms from the 1991 legislation had actually been implemented by 1993, P.A. 93-228 went substantially further than the 1991 legislation had gone in revamping the medical components of the system. Those changes are outlined in Table V-2.

Table V-2. Public Act 93-228: Required Medical Component Changes	
Legislated Changes	**Implementation Status**
Elimination of the "opt-out" clause that had permitted injured workers to seek medical treatment outside of the employer's managed care plan	Still appears in regulations, but approved plans indicate the requirement for all employees to seek treatment by those in the plan.
Requires the chairman of the Workers' Compensation Commission to establish a medical fee schedule, and to limit the annual growth of total medical fees to no more than the annual increase in the Consumer Price Index for all urban workers, and to prohibit medical providers from recovering from claimants any charges over and above those set in the schedule.	Chairman has done this, with the advice of the Medical Advisory Board. The fee schedule is one developed by Medicode, Inc., located in Salt Lake City, Utah. All fee schedules must be purchased through Medicode, although there is a copy available at each workers' compensation office. The fee schedule went into effect in 1994, and, except for a few procedures, the 1994 reimbursement rates are still in effect.
Requires the chairman to develop medical billing guidelines that include procedures for resolving billing disputes.	Chairman has done this.
Requires the chairman to develop medical practice protocols for reasonable and appropriate treatment of workplace injuries.	Chairman has stated that these have been developed, but have not yet been implemented because they were awaiting legislation indemnifying those involved in protocol development. That legislation was adopted during the 1995 session, via P.A. 95-240, and the first protocols became effective in January 1996.
Development of medical utilization review procedures to evaluate the necessity and appropriateness of medical care provided to claimants.	The WCC approves those utilization review organizations that are licensed by the Insurance Department. Also, the standards set by the Insurance Department are also the accepted standards for the WCC.

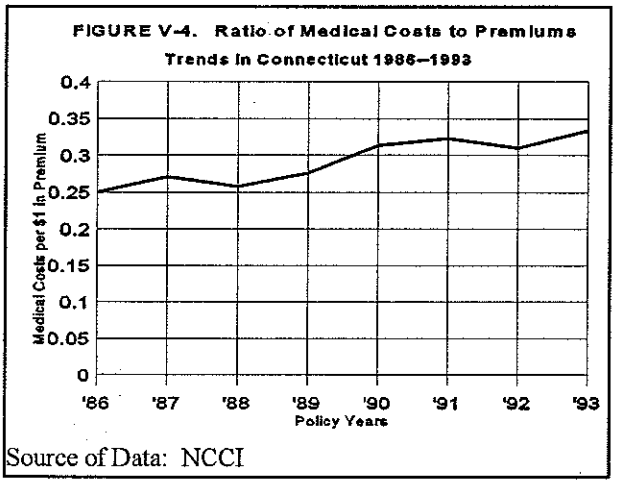
Analysis of Medical Costs

The total amount of projected workers' compensation medical costs in Connecticut for policy years 1986 through 1993, as reported by the National Council on Compensation Insurance, is shown in Figure V-3. These costs reflect the expected medical losses that will ultimately be paid for injuries that took place during these policy years. As the graph shows, until 1989 there had been significant growth in aggregate medical costs for those who purchase workers' compensation insurance, but since 1989 total medical costs for that market have been declining.

However, as with the indemnity benefits, the decline in total medical costs is at least in part due to the decrease in the number of employers who purchase private insurance. Predictably, if you collect less in premiums, total costs should also decline. To better gauge the relationship between the change in premiums written, a measure of private insurance coverage, and medical expenditures, the committee plotted the ratio between the two variables. The results of the medical loss ratio in Figure V-4 show a different picture from that of total medical costs. Instead of a declining line showing medical costs decreasing as in Figure V-3, Figure V-4 shows the ratio line is increasing.



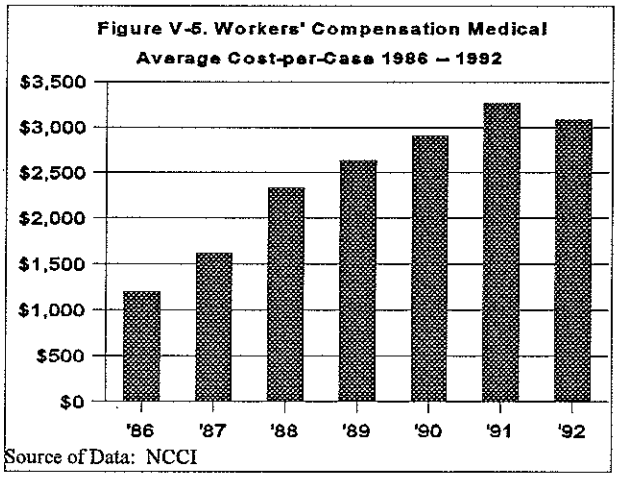
Source of Data: NCCI



Source of Data: NCCI

The results of Figure V-4 mean that for every dollar collected in premiums for 1986, an expected 25 cents was forecasted to pay for medical costs. In 1993, the dollar collected in premiums will ultimately pay for about 33 cents in medical benefits. The fairly steep slope in the ratio line indicates that the decline in aggregate medical costs shown in Figure V-3 is related to the decline in in the number of companies paying private insurance premiums.

In addition to examining NCCI's forecasted medical costs in the aggregate, and the ratio of medical costs to premiums paid, committee also looked at average medical costs per case. The illustrated data in Figure V-5 are annual average medical costs for all privately insured workers' compensation cases. As the graph shows, the average medical costs per case grow rapidly -- from about $1,200 in 1986 to more than $3,200 in 1991. In 1992, the average medical cost per case dropped about 5 percent to $3,079. The data from that point are unavailable, so it is too early to determine whether this is a trend.



Source of Data: NCCI

Findings and Recommendations on Medical Reforms

The analysis above indicates that it is largely too early to tell what impact the medical reforms will have on medical costs. The National Council on Compensation Insurance, in its initial pricing of the 1993 reforms, estimated that 2 percent of the 19 percent mandated reduction in premiums would be due to medical cost declines from managed care plans. Since that time, the rating organization has attributed no additional price reductions from managed care plans, as experience data since their inception are still too premature. The rating organization also believes that, since managed care plans are not mandated for the entire system, most savings would be on an individual company basis. Therefore, NCCI indicates that pricing would be better left between individual employers and their insurer rather than making an overall change in the rates.

However, a study of two pilot managed care programs in Florida showed savings of about 50 percent of previous medical costs. Further, early indications from those large self-insured employers in Connecticut who have implemented managed care show that the costs savings can be significant, and the savings result not only in medical costs, but in reduced indemnity payments when a claimant is returned to work earlier, or is given a lower permanency rating for an injury. For example, the Workers' Compensation Trust, a self-insured group formed by the Connecticut Hospital Association, implemented an approved managed care plan in January 1995 and has experienced a 19 percent reduction in indemnity costs and a 31 percent decrease in medical costs for the first 6 months of 1995 over the same period in 1994.

Similarly, the State of Connecticut has demonstrated that savings may be realized with managed care. The state was the first employer to implement an approved managed care plan in September 1993. Medical costs were reduced from $22.4 million in FY 93 to $19.6 in FY 94 and to $19.3 in FY 95. Wage loss payments grew in the first year of the managed care plan -- from $41.8 million in FY 93 to $44 million in FY 94, but were substantially reduced to $39.1 million in FY 95. Of course, how much of the reduction in indemnity costs is due to managed care influence and how much is due to decreases in benefit rates is difficult to calculate.

The 1995 NCCI rate filing did allocate a predicted reduction of 1.1 percent in total workers' compensation costs due to the introduction of the medical fee schedule in Connecticut. The calculations used to arrive at this were adjusted downward based on a California study showing utilization increased significantly under fee schedules.

In summary, the impact of the legislative reforms on medical costs is still uncertain. No systemwide data on medical costs are available since the managed care plans and the fee schedule have been implemented. The NCCI predictions are for small initial declines in overall costs, despite study results such as the ones in Florida, showing that managed care plans may cut costs significantly. Further, as discussed in the cost section above, NCCI's analysis of medical cost experience forecasts continued growth in medical expenses as a percentage of workers' compensation premiums collected.

The program review committee believes that, in setting rates, rating organizations may be

overly cautious in estimating any reductions that might occur from systemic or law changes, while stretching the predicted increases in rates from other changes. The committee concluded -- based on results of managed care cost reductions in other states like Florida, and early indications of cost decreases here in Connecticut -- that employers with managed care plans must be assured that cost decreases are translated into reduced rates for them. Thus, the Legislative Program Review and Investigations Committee recommends that:

> **the workers' compensation rating organization in Connecticut and workers' compensation insurers develop and file separate rates for those employers with managed care plans and those without.**

The committee believes that separate rating is the only way to really ensure that employers with managed care plans are realizing the benefits of any cost reductions and are not sharing those reductions with other employers who have not implemented such plans but may be reaping the benefits because they are in the same rating classification. Further, the committee believes that cost reductions due to managed care should be significant enough to produce different experience data from those employers who don't have managed care, that those data ought to be examined and filed separately, and, where warranted, different rates should be proposed.

In addition, the program review committee believes that, as the use of managed care plans becomes more popular in workers' compensation, more information will become available on changes in medical costs, along with Connecticut data on the utilization and costs of the fee schedule, as required by the Workers' Compensation Commission. Thus, the program review committee recommends that:

> **the Workers' Compensation Commission and the Insurance Department review the results of these medical cost and utilization data as they become available to ensure that employers are capturing the benefits of any medical cost savings in their workers' compensation insurance rates.**

Perceived Impact of Medical Reforms on Business and Labor

As mentioned above, no data are available yet that accurately measure the impact of the medically related reforms on costs or treatment of injured workers. As a way to gauge satisfaction with the medical reforms, the committee surveyed approximately 415 businesses and about 450 organized labor representatives. Fifty-three of the 415 employers (13 percent) and 61 of the 450 (13.5 percent) labor groups responded. Since the response rate is very low, caution is advised in interpreting the survey results. Table V-6 illustrates business perceptions regarding the impact of the medical reforms on their constituent group.

Table V-6. Business Reaction to Workers' Compensation Medical Reforms			
	Yes %	**No %**	**Too Soon To Tell %**
Have an Approved or Submitted Managed Care Plan (MCP) N=47	32%	68%	
Believes that MCP has made a difference in medical claims N=17	18%	41%	41%
Reforms have lowered medical claims costs N=49	12%	88%	
Source of Data: Survey of Connecticut Businesses			

Almost one-third of the businesses that responded already have in place, or have submitted, a managed care plan for approval, and all of the respondents with approved plans were satisfied with the process for approval. However, the responses about the results of those plans are more negative. Only 12 percent think that reforms have lowered medical claims costs, 41 percent found no difference, and 41 percent said it was too soon to tell.

Labor leaders were also negative about the medical care reforms, but again caution is required since the response was so small. As indicated in the table below, 42 percent of those labor groups who responded were covered under a managed care plan, and another 23 percent weren't sure. Of those covered by plans, only 22 percent were satisfied with the treatment provided, while the remaining 78 percent were not.

Table V-7. Organized Labor Representatives' Reaction to Workers' Compensation Medical Reforms			
	Yes %	**No %**	**Not Sure%**
Covered by an Approved Managed Care Plan (MCP) N=57	42%	35%	23%
Satisfied with treatment offered under MCP N=23	22%	78%	
Source of Data: Survey of Labor Leaders			

Certainly labor is bound to be unhappy regarding the changes in medical coverage brought about by managed care plans. The plans place limitations on the providers an injured worker may see, typically restricting choice to those providers in the network, and almost always requiring a gatekeeper or referring physician to see a specialist, and often also requiring preapproval of certain types of treatment or diagnostic tests. But these are the basic tenets of managed care, and can't be altered within the standard managed care model.

However, in interviews with organized labor leaders, there appears to be two other major reasons that labor leaders are unhappy with the managed care plans. First, they believe workers are not well informed about whether they're under a managed care plan or not, and if so, what are their rights, responsibilities, and choices under such plans. This charge seems to be substantiated by the fact that 23 percent of labor representatives don't know whether their workers are covered by a plan or not. While the regulations require that educational material be developed for employees, and included with the proposed plan, there currently is no monitoring or oversight about how the workers are informed about the plans.

Secondly, labor representatives believe that workers are being sent back to work too quickly, sometimes the same day they're injured. Labor believes this is focused on saving money, but to the detriment of injured workers. These claims are anecdotal at this point. There are no aggregate data since 1993 that compare treatments pre- and post-reforms, nor data that compare treatments of individuals within managed care plans and those outside the plans.

To resolve the problems of inadequate information about the plans disseminated to workers and perceived quality issues, such as returning injured workers to the job too quickly, the Legislative Program Review and Investigations Committee recommends the following:

The Workers' Compensation Commission develop an oversight capability to monitor how insurers and/or employers are disseminating information about their managed care plans. The goal should be that workers know:

- **what their rights and responsibilities are for seeking medical treatment, both initial and referral to specialists, under workers' compensation managed care;**
- **who the current providers are under their employer's managed care plan; and**
- **how to proceed if he or she has a question, concern, or complaint about medical treatment provided.**

Now that the initial plans have been approved, the WCC staff should be able to focus more time and effort to ensuring the plans are operating according to the standards approved in the written

plan. In meeting this recommendation, the WCC should consider having its education staff produce a video to better inform workers about these issues. The program review committee also believes that:

> **The Workers' Compensation Commission must develop the capability to analyze aggregate data on utilization to ensure that quality of medical treatment provided to workers under managed care plans is not compromised.**

To do this, the Workers' Compensation Commission should review data from the NCCI, as it becomes available, on the medical treatment provided to workers for certain injuries before and after the 1993 reforms. In addition, the WCC should examine utilization review data from the licensed organizations approved to perform utilization review functions, and compare those data with aggregate NCCI detailed claim information data to assess whether workers are receiving quality care under the approved managed care plans.

This is not to say any differences in the results mean managed care plans compromise quality. However, a wide variation in the treatment or dramatic differences in the days before return to work, for the same or similar condition, could signify problems with quality.

Workers need to be assured there are checks on the medical care being provided under such plans. While employers have been offering managed care to their workers for group health for some time, there is a difference. Group health plans are optional benefits that an employer provides to his or her workers, while workers' compensation medical benefits are required by law to be provided to any worker who suffers a work-related injury or accident. The Workers' Compensation Commission must ensure that workers can have confidence in the medical treatment they're being provided.

CHAPTER VI

WORKPLACE SAFETY

Background

It is widely recognized that one of the most significant ways to reduce workers' compensation costs is to prevent the injury or illness from happening in the first place. One of the ways of doing that is to improve workplace safety. Up until 1991, workplace safety was an option left to employers and their insurance carriers. Certainly, employers have had to comply with standards set by the Occupational Safety and Health Administration (OSHA), and report on the incidence of workplace safety and illnesses, as required by OSHA, but no other direct government mandates had been placed on employers to take actions that might reduce workplace accidents or injuries.

Public Acts 91-339 and 93-228

In 1991, as part of P.A. 91-339, all employers with 50 employees or greater that applied for a managed care plan were required to establish a health and safety committee. The law required the committees to be composed of both labor and management. Since the regulations concerning the managed care plans did not go into effect until March 1993, few plans were approved before 1994. As a result, the original health and safety committee requirement was not actually implemented before new provisions were passed during the 1993 legislative session.

Public Act 93-228 extended the requirement to establish health and safety committees to employers with 25 or more employees, and employers with fewer than 25 if the employer's OSHA workplace injury and illnesses incident rate exceeds the statewide average, which is currently 4.4 incidents per 100 workers. Further, P.A. 93-228 required that the chairman of the Workers' Compensation Commission, in consultation with the labor commissioner, adopt regulations to carry out the establishment of the health and safety committees. The act mandated that the regulations specify:

- the composition of the committees, ensuring representation from management and workers;
- the frequency of committee meetings;
- requirements for record keeping of meetings, and that such records be open for inspection by the WCC chairman or his designee;
- that employee members be compensated at their regular rate of pay for time spent on committee business;

- the duties and functions of the health and safety committees, including: A) establishing procedures for workplace safety inspections by the committee; B) establishing procedures for investigating all safety incidents, accidents, illnesses, and deaths; C) evaluating accident and illness prevention programs; D) establishing training programs for the identification and reduction of hazards in the workplace that damage the reproductive systems of employees; and E) establishing training programs to assist committee members in understanding and identifying the effects of employee substance abuse on workplace accidents and safety; and

- guidelines for the training of safety and health committee members.

The act also stated that if an employer had in place on July 1, 1993, a health and safety program, or other program determined by the chairman to be effective in the promotion of health and safety in the workplace, then that employer would not be required to comply with the specifics of the health and safety committee requirements.

Current Implementation Status

Almost two years lapsed from the time the 1993 legislation was adopted and when the regulations finally took effect in May 1995. Although the act required that regulations be adopted that establish criteria for evaluating pre-existing programs, no separate regulations have been developed for this purpose. Instead, there is a provision in the regulations adopted in May 1995 that addresses pre-existing programs. That provision states that an employer will not be required to establish a safety and health committee if the employer can demonstrate that, prior to July 1, 1993, there was a "committee or program [is] in substantial compliance with the provisions of the regulations." (Sec. 31-10)

Since the regulations were promulgated in May 1995, the WCC has hired a coordinator of safety and health services and four safety program officers. In September and October of 1995, the staff visited 292 companies or businesses, and conducted 30 presentations at business or organizational conferences or seminars.

According to the coordinator, the program is first concentrating on employers with 25 or more employees, and has not yet begun to focus on those smaller employers with worse than average safety records. It is impossible to assess at this point how many employers are in compliance with the health and safety requirements. .

Analysis and Findings Concerning the Promulgation of Regulations

The program review committee's supporting and supplementary findings concerning both the promulgation of regulations for the committees and the technical advice and monitoring concerning the establishment of Health and Safety Committees follow.

- *The regulations concerning the committees took almost two years to promulgate, becoming effective only in May 1995. The chairman of the Workers' Compensation Commission did consult with the labor commissioner on the development of the regulations for the Health and Safety Committees as required in the law. However, the drafts of the regulations developed by the Department of Labor (DOL) and the Workers' Compensation Commission were substantially different. The DOL's were much more detailed, and gave greater guidance in terms of how these committees should be selected, gave the committees the right to make recommendations for improvements in the employer's health and safety program, and corrections of hazards to employee safety or health. The DOL proposed regulations further specified that, while the committees' recommendations would be considered advisory, the employer was mandated to respond in writing in a timely manner.*

- *The DOL deputy commissioner testified at a hearing on May 5, 1994, on the proposed regulations, and stated " the regulations before us allow -- and in some ways encourage -- the establishment of paper committees that will be wholly unable to address the underlying issues that motivated the General Assembly [to establish such committees]".*[5]

- *There were also concerns raised at that same public hearing that the regulations may be in conflict with provisions contained in the National Labor Relations Act (NLRA), and National Labor Relations Board (NLRB) case law, concerning what constitutes a labor organization. The Department of Labor proposed specific language at the hearing it believed would have prescribed representation on the committee and still met the NLRA standards.*

- *In June 1994, the Chairman of the WCC sought an opinion from the Attorney General's office on the proposed regulations and whether or not they violated provisions of the National Labor Relations Act. Chairman Frankl notes in the letter requesting the opinion a special concern -- " At the hearing [on May 5, 1994] several witnesses indicated that the NLRB has filed a lawsuit against the state of Tennessee after it promulgated regulations similar to our regulations for safety and health committees".*[6]

- *The attorney general provided an official opinion in November 1994, indicating that the "regulations in question do not violate the National Labor Relations Act,*

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[5] Deputy Commissioner Robert F. Tessier, testimony on safety and health regulations, May 5,1994. p.2.

[6] June 30,1994 letter from WCC Chairman Frankl to Attorney General Blumenthal requesting a formal opinion on the safety and health regulations.

[but] the regulations may need to be amended in certain respects after public comment to clarify their scope and operation." The opinion indicated that sections concerning the committee's membership and composition along with their duties and functions, may have to be clarified.

- *In response to this opinion, two important clarifications were made to the proposed regulations: 1) requiring that nonmanagerial employee members of the committee be selected by nonmanagerial employees; and 2) the functions and duties were changed from "developing procedures" to "developing procedures for sharing ideas" on aspects of safety in the workplace.*

- *In a discussion with staff in the Attorney General's Office who worked on the decision, the program review committee staff learned there was some concern in that office about whether the committees could in fact be established at all, given the provisions of the NLRA. The attorney general's staff believed that these changes in the regulations were necessary so that the committees could exist, given the NLRA standards.*

- *The regulations adopted, which are almost entirely the ones proposed by the WCC, are brief, do not provide much guidance or clarity of the statute, and in fact, dilute the role of the health and safety committees in describing their duties.*

- *The 1993 act required the health and safety committees to: " A) establish procedures for workplace safety inspections by the committee; B) establish procedures for investigating all safety incidents, accidents, illnesses and deaths; and C) evaluate accident and illness prevention programs; D) establish training programs for the identification and reduction of hazards in the workplace that damage the reproductive systems of employees; and E) establish training programs to assist committee members in understanding and identifying the effects of employee substance abuse on workplace accidents and safety. The regulations, however, limit the committee's role to one of "developing procedures for sharing ideas" in the above areas.*

Comparison with Other States

Approximately 16 other states have required employers to establish safety programs at their work sites, as part of workers' compensation reforms. Most of these programs require joint labor management safety committees. A review by the program review committee of the regulations in place in five of those states show that no other state, including Tennessee, whose regulations had come under some legal review, had regulations as vague and weak as ours. Most provide some means of enforcement to establish these committees.

Some other states have placed their health and safety committees under the aegis of their state OSHA. For example, Oregon, which required these committees back in 1990 and which is often cited as the model state in the area of health and safety committees, placed the responsibility for monitoring the committees under Oregon OSHA, but it also added significantly to its OSHA staff. Since that time, the number of OSHA citations for serious violations and accompanying penalties have increased in Oregon, and that state has seen a sustained reduction in workplace injuries. It is difficult to point to the health and safety committees' actual role in that reduction, but studies have found that they have contributed in lessening the incidence.

In its 1993 reforms, the legislature chose not to place the committees under OSHA, and not to statutorily provide penalties for not complying with the committee requirement. The regulations promulgated by the WCC expand that approach by stating "the purpose is . . . to bring employers and employees together in a nonadversarial, cooperative and effective effort to promote safety and health at each work site."

The literature suggests this cooperative approach can also be successful. In Michigan, a study of that state's employers found employers with safety intervention and disability management strategies that are proactive and management environments that are more participative had better performance on lost-time injuries than those with weaker programs.[7]

Response from Business and Labor

Connecticut businesses responding to a survey from the program review committee seem to have a positive response to this cooperative approach to workplace safety committees. The table below contains the results to businesses' responses to the health and safety committees mandated in the 1993 reforms. Interpretations of the data must be tempered by the fact that the survey response rate was low -- about 13 percent.

Table VI-1. Business Response to Survey Concerning Health and Safety Committees

Question	Yes %	No %
Do you have, or are you now establishing, a Health and Safety Committee at your workplace? N=58	53	47
Has the committee lessened the number of workplace injuries N=30	63	37
Have reforms increased your safety efforts at your business N=51	57	43
Source of Data: Survey of Connecticut Businesses		

[7] Allan H. Hunt and Rochelle V. Habeck, "Disability Prevention Among Michigan Employers," W.E. Upjohn Institute for Employment Research, Kalamazoo, MI, 1994.

The table below shows the results to similar questions posed in a survey sent to 450 leaders of union locals throughout the state. Sixty-one responses (13.5 percent) were received to the survey, a similar response rate to the business survey, so caution must be used in assessing these results as well.

Table VI-2. Labor Responses to Questions Concerning Health and Safety Committees

Issue	YES %	NO %
Established Health and Safety Committees N=58	53	41
Members Favor Health and Safety Committees N=56	100	0
Health and Safety Committees Reduce Injuries N=53	83	17
Source of Data: Responses to Labor Leader Survey		

Findings and Recommendations

In conclusion, the program review committee finds that the regulations have now been promulgated for the health and safety committees, although substantially behind schedule. The regulations promote a cooperative approach to health and safety in the workplace that appears to be well-received by both business and labor, and has been shown in the literature to be a potentially effective way to reduce illnesses and injuries. It is still too early to evaluate whether this approach will be effective in Connecticut, as the monitoring of the establishment of these committees has just begun.

As noted previously, there was a substantial lag in promulgating these regulations, but the committee concluded that the reasons for the delay were valid. The regulations in effect dilute the statutory role of the health and safety committees, but the chairman of WCC had an official legal opinion on which to base those changes. At the same time, other states that have adopted regulations give these workplace safety committees greater responsibility despite having to meet the same federal labor relations guidelines as Connecticut.

The Workers' Compensation Commission has begun to implement the regulations through hiring staff, conducting presentations, and making site visits. However, to date the WCC does not have an accurate number of employers that are in compliance.

In light of the above findings, the Legislative Program Review and Investigations Committee recommends the following:

- **the regulations as promulgated continue to serve as the guidelines for implementation of the health and safety committees in the workplace;**

- **the Legislative Program Review and Investigations Committee, in cooperation with the Labor and Public Employees Committee, review the results of these committees at the end of calendar year 1998 to evaluate whether the committees, as constructed and authorized under the current regulations, should be rewritten to be more in line with the legislation contained in P.A. 93-228;**

- **the criteria used in the review should include, but not be limited to: employer compliance with the health and safety committee requirements; business and labor opinion; and impact of committees in reducing work-related injuries; and**

- **the Workers' Compensation Commission's current monitoring efforts should first concentrate on those employers with more than 25 employees but with worse than average safety records.**

CHAPTER VII

FILING OF FIRST INJURY REPORTS

The Workers' Compensation Commission, through its statistical division, is responsible for compiling and maintaining statistics concerning occupational injuries and diseases. The main source of these statistics is through the *First Report of Injury.* Each employer in the state is statutorily required (C.G.S. Sec. 31-316) to keep a record of each work-related injury by an employee that results in an incapacity or lost work of one day or more, and must send those records in duplicate to the chairman of the Workers' Compensation Commission at least weekly. The statute also indicates that no other state agency may require the filing of these or similar accident reports, but that the duplicates shall be transmitted from the WCC to the labor commissioner.

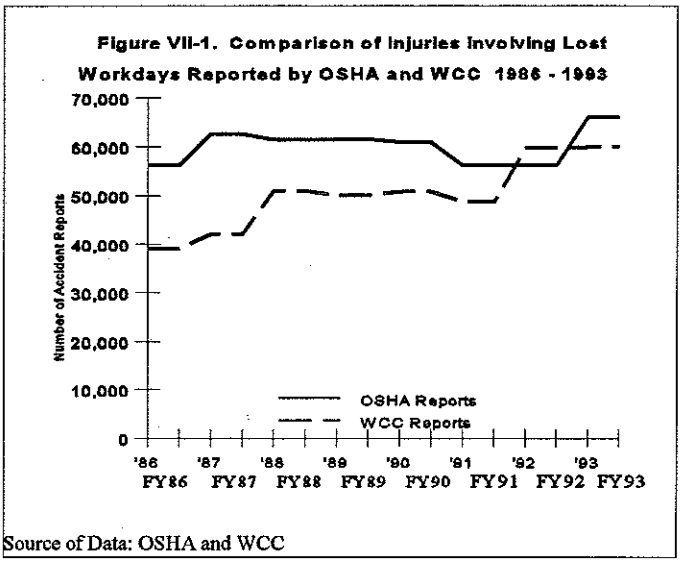
The state Occupational Safety and Health Administration also collects data on injuries and illnesses in the workplace, and issues an annual report that categorizes these incidents by industrial category, and state and local government. Each state collects and reports these data in a similar way. However, the data are based on a survey of the employers in each state. In Connecticut, 7,000 private and 1,000 public employees are surveyed.

Based on the collection methods, the data filed with the Workers' Compensation Commission on injuries and illnesses in theory should be the most inclusive of what is actually occurring in the workplace. There is, however, no penalty on employers for not filing these injury reports. This is not the case for employees. Since 1991, via P.A. 91-32, each employee who sustains an injury at the workplace is required to report it immediately to the employer or the employer's representative. If the employee fails to report, C.G.S. Sec 31-294b allows a workers' compensation commissioner to "reduce the award of compensation proportionately to any prejudice that he finds the employer has sustained by reason of the failure. . . ."

In reality, employers have at least the same, if not greater, incentive not to file the report of an employee's injury. For example, reported workplace injuries may: jeopardize a unit's safety record, and sometimes accompanying monetary rewards; increase insurance premiums; or establish clearer employer liability to a worker's claim for compensation.

While there is really no way to verify employer compliance, there are indications that workplace injuries and accidents are somewhat underreported to the Workers' Compensation Commission. Figure VII-1 compares accident data collected by the Connecticut Department of Labor, Division of Occupational Safety and Health, with data collected by the WCC. Some caution is needed in interpreting the data because the collection time frames between the two agencies are different. OSHA reports the data on a calendar year basis, while the WCC reports the data for the state fiscal year. Even taking these differences into account, Figure VII-1 makes it clear that the accidents reported in response to OSHA's survey are -- with the exception of 1992 -- consistently and substantially higher than those lost-time injuries reported to the WCC.

For example, in calendar year 1993, the most recent report of OSHA statistics shows that there were about 66,000 accidents where there was one or more lost workdays. However, the statistics generated by the WCC, using the first reports of injuries that result in an incapacity of one day or more show a total of slightly more than 60,000 accidents for FY 93.



Source of Data: OSHA and WCC

The importance of filing these injury reports becomes more acute as the WCC begins to monitor employers in order to fully implement the mandates concerning the worker health and safety committees required in P.A. 93-228. The act mandates each employer with less then 25 employees, but that has an injury incidence rate that is higher than the statewide average (currently 4.4 incidents per 100 workers), be required to establish a health and safety committee. As mentioned in the section of this report discussing those committees, thus far the WCC has concentrated on the employers with 25 or more employees. But, as the WCC's focus broadens to include all mandated employers, the reports filed with the commission will be the most inclusive record of accidents at each state employer's work site, as well as the statewide aggregate.

To ensure compliance with the filing requirements, similar penalties must be imposed against employers as those assessed against employees who don't file an injury report. At the same time the WCC, through its education staff must improve employer awareness of their responsibility to file these reports with the commission. Therefore, the Legislative Program Review and Investigations Committee recommends the following:

- **Section 31-316 of the Connecticut General Statutes be modified to indicate that if an employer fails to report the notices of injuries as required, the workers' compensation commissioner, upon a determination that the employer did not file the report, may increase the award for compensation to the injured employee proportionately to the prejudice that the employee sustained by reason of the employer's failure to file; and**

- **Staff in the WCC assigned to educate employers and employees about workers compensation should bolster efforts to educate employers of the statutory requirements to file the first reports of injury with the Workers' Compensation Commission. The forms themselves should be modified to include when, how, and to whom the form should be filed.**

The committee believes that, if employers are better informed about the submission of the injury report forms and the importance of their filing -- both on an individual and aggregate basis -- and an economic disincentive for not submitting the reports is created, the recording of the reports will improve. The recommendations will: provide equal statutory treatment of both employees and employers for non-compliance; reduce the occurrence of disputes before the commission about compensability when no report is on file but should have been; and ensure more accurate statistical records on workplace injuries in Connecticut, which will be essential in meeting the statutory mandate for establishing health and safety committees for all required employers.

CHAPTER VIII

ENFORCEMENT OF INSURANCE COVERAGE

Protection against workers' compensation liability, either through private insurance or through self-insurance, is statutorily required of virtually all employers who use the services of one or more persons for pay. Each employer must display proof of coverage or self-insurance certification in a conspicuous place that can readily be seen by all employees, and the posting must be updated each time coverage changes.

Penalties and Enforcement Concerning Coverage

There are several statutes that provide for the enforcement of the workers' compensation law and the imposition of penalties for non-compliance. Several entities including the Workers' Compensation Commission, the attorney general, the state treasurer, and the state's attorney all have roles in the enforcement.

Penalties. Generally, employers are required to comply with all sections of the workers' compensation statutes. The following are statutory provisions that can be used in the enforcement of either specific or general workers' compensation insurance coverage requirements:

- Section 31-288(c) provides civil penalties for not carrying workers' compensation insurance. Prior to the 1993 reforms, the civil penalty a workers' compensation commissioner could impose for failure to comply with the workers' compensation or self-insurance provisions was $1,000. Public Act 93-228 increased that amount to $10,000. (P.A. 95-277 raised the amount to $50,000; this act will be discussed later in this chapter in more detail);

- Section 31-289(a) states that, if after 90 days of the imposition of the civil penalty, or the final disposition of an appeal, the civil penalty is not paid, the attorney general may bring a civil action to recover double the amount of the civil penalty, together with reasonable attorney's fees and costs;

- Public Act 93-228 authorizes legal action whenever an employer wilfully and repeatedly fails to comply with the requirements of the statutes governing workers' compensation. Section 31-289(b) states that the attorney general may bring a civil action in the Superior Court to enjoin the employer from conducting business in this state until the employer fully complies with the requirements of the statutory provisions concerning workers' compensation;

- Section 31-284(e) states that the attorney general may bring a civil action in the Superior Court to enjoin the employer, until such time as he fully complies with the workers' compensation insurance coverage requirements, from entering into any contracts of employment as a result of which he will employ additional employees; and

- Section 31-288(d) requires that an employer be charged with a class D felony if he or she attempts to defraud or deceive any insurance company by knowingly misrepresenting one or more employees as independent insurance contractors; or knowingly provides false, incomplete, or misleading information to such company concerning the number of employees, for the purpose of paying a lower premium on a policy obtained from such company.

Enforcement agencies. As mentioned above, there are several agencies that have roles in enforcing employers to carry workers' compensation insurance. Their roles and activities are discussed below.

Investigations of non-coverage are handled by a unit composed of inspectors located in the Office of the State Treasurer and funded through the Second Injury Fund assessment. The unit was recently transferred back to the treasurer's office (through P.A. 95-277) following its shift from there to the Workers' Compensation Commission via the 1993 reform legislation. The unit is responsible for verifying compliance with the insurance coverage requirements through field inspections, complaint investigations, and the like. If, after investigation, non-compliance is found, the investigators report to the workers' compensation commissioner, who should schedule a hearing and assess a penalty if a violation of the coverage requirements is determined.

Based on interviews with the supervisor of investigations, most of the coverage inspections are undertaken without leads as to which employers may or may not be complying with the coverage requirements. The supervisor indicated that the inspectors used to receive lists of facilities and persons licensed by the Department of Consumer Protection, but they no longer receive those. Further, little is done to narrow the focus of investigations by comparing Department of Labor records on employers to the commission's automated list of insured employers and its list of self-insurers.

Investigative Unit Activities

Table VIII-1 shows statistics from the Second Injury Fund investigative unit concerning efforts to verify compliance with insurance coverage requirements. As the table shows, the number of visits declined sharply between FY 92 and FY 95. The number of employers indicated as having no insurance also dropped in total numbers, but not as a percentage of visits made.

If the investigative unit refers a case of non-coverage to the Workers' Compensation Commission, a commissioner may impose a civil penalty. The amounts collected in civil penalties for

non-coverage of workers' compensation over the past six years are displayed in Table VIII-5, later in this chapter. As Table VIII-5 indicates, the amounts have not been great in any year, although the amounts appear to be increasing especially for FY 95.

Table VIII-1. Investigative Unit Activities – FY 92 to FY 95				
Activities	**FY 92**	**FY 93**	**FY 94**	**FY 95**
Visits	3,780	3,710	2,957	2,794
Insurance Not Required	478	629	499	541
No Insurance	291	333	210	159
2nd Visit Coverage	189	135	119	106
Cited	268	200	129	103
Source of Data: Reports of Investigations Unit To Chairman of WCC				

Fraud investigations. While not part of either pieces of the reform legislation, in 1992 (P.A. 92-173) the legislature created a workers' compensation fraud unit in the State's Attorney's Office. The unit consists of one prosecuting attorney, three inspectors, and clerical support. It is charged with investigating cases of alleged fraud involving claims, receipt or payment of benefits, provider fraud, as well as the insurance or self-insurance coverage requirements. Typically, complaints are received from insurance companies, co-workers, or the general public. The unit, which is funded by the Workers' Compensation Administration Fund, must submit quarterly reports on its activities to the chairman of the Workers' Compensation Commission and the advisory board.

Table VIII-2 displays the activities and outcomes of the fraud unit in the State's Attorney's Office since the legislation creating it was enacted in 1992. The statistics are for varied time periods, because of varied reporting. There also is likely overlap in some categories -- e.g., current investigations and trials pending -- because they can be carried over from the previous time period.

Table VIII- 2. Activities and Outcomes of State's Attorney's Workers Compensation Fraud Unit October 1992 -March 1995.				
Time Period	**Complaints Rec'd**	**Current Investigations**	**Arrests**	**Pending Trial**
Oct. 1992 - Sept. 1993	230	71	38	15
Oct. 1993 - Dec. 1993	61	68	1	7
Jan. 1994 - Dec. 1994	225	60	23	--
Jan. 1995 - March 1995	34	53	5*	10
* Pending judicial signature Source of Data: Reports from the State's Attorney's Workers' Compensation Fraud Unit to Chairman Frankl				

Problem of Non-Coverage

When a claim is filed and the employer is found to be uninsured or is insolvent, and cannot or will not pay the costs of the claim, the Second Injury Fund (SIF) must pay. The cost to the fund for payment of claims to employees of uninsured or insolvent employers has been growing. Table VIII-3 shows the trend of SIF payments from FY 90 through FY 95, and as the table shows, the claims paid for uninsured employers has almost doubled since FY 90. Furthermore, the chances of any recovery for payments made on behalf of uninsured workers is small. Of the total $16.1 million expended during the FY 90-95 period illustrated, the amount recovered was slightly less than $1.4 million.

Table VIII-3. Trends in SIF Claim Payments for Uninsured Employees

Fiscal Year	Amount Paid from SIF	Percent Annual Growth
FY 90	$2,098,476	-2.9%
FY 91	$2,085,974	-0.6%
FY 92	$2,271,041	8.9%
FY 93	$2,831,288	24.7%
FY 94	$2,764,246	-2.4%
FY 95	$4,162,758	50.6%
Total FY 90-95	$16,213,783	98.4%

Source of Data: State Treasurer's Office, Second Injury Fund

While the claims paid on behalf of uninsured employers remains a small amount of all SIF claims paid -- less than 1 percent -- the potential problem of uninsured employers and its impact is much greater. A committee staff review of WCC cases that had a formal hearing in March of 1995 found that approximately 7.5 percent of the files (13 of 175) involved employers with no insurance. This undoubtedly understates the problem, since the only employers who surface are those whose employees gets injured and file a claim.

The percentage of "no-insurance" cases found in the staff's file review is very similar to the percentage of businesses found without insurance as a result of inspections conducted by the Second Injury Fund investigative unit, whose activities were discussed above. As Table VIII-4 indicates, over the past few years the average percentage of businesses found with no insurance was 7.5 percent of all employers inspected. If the two estimates of the extent of the non-coverage problem are valid, the issue is not a minor one. For example, 7.5 percent of all Connecticut private employers is about 9,000 businesses uninsured.

Table VIII-4. Percent of Employers Inspected Found Without Insurance			
Fiscal Year	**Number of Visits**	**Number Without Insurance**	**% of Visits --Employer without Insurance**
FY 92	3,780	291	7.6%
FY 93	3,710	333	8.9%
FY 94	2,957	210	7.1%
FY 95	2,794	159	5.6%
Total	13,241	993	7.5%
Source of Data: Reports of SIF Investigative Unit			

Of course, payments from the SIF is only one aspect of the non-coverage problem. The other part of the problem is that those employers who don't cover their liability are enjoying an unfair competitive advantage over employers who do insure or self-insure their liability. Those employers who circumvent the business costs of paying workers' compensation premiums or setting aside self-insurance reserves can offer their goods and services more cheaply, thus providing a disincentive for any employer to cover his or her workers' compensation exposure.

Analysis of Enforcement Results

As discussed above, there are a number of statutory enforcement mechanisms available to ensure workers' compensation coverage by employers. One of those enforcement tools is to levy a civil penalty. However, few of these penalties have been imposed in the past. Table VIII-5 on page 92 shows that only a total of $15,050 had been collected in civil penalties from FY 90 through FY 95. Staff with attorney general's office stated no civil action has been pursued because of non-payment of civil penalties. In addition, computer records at the state Judicial Department indicated no judicial dispositions have been recorded concerning employer fraud under Section 31-288(d), since the law took effect in 1993.

Enforcement Mechanisms in P.A. 95-277. However, as noted previously, during the 1995 legislative session, the General Assembly enacted P.A. 95-277, increasing civil penalties for non-coverage from a high of $10,000 to an overall $50,000 maximum. It also introduced a minimum fine of $5,000 or $500 per employee, and included penalties of $100 per day for each day of continued violation. Even more important than the increase in fines is the fact they are mandatory. In addition to the civil penalty, P.A. 95-277 made deliberate non-coverage a class D felony.

The act requires that when a Second Injury Fund investigator finds an employer with no workers' compensation insurance, a citation be issued requiring the employer to comply with the coverage requirements, and advising him or her of the penalty for failure to do so and that a Workers' Compensation Commissioner will hear the case. The investigator must file a request for a hearing on the matter, and the commissioner is required to hold a hearing within 30 days. The act allows the SIF, as well as commissioners, to initiate employer investigations.

Table VIII-5. Civil Penalties Collected for Non-Coverage: FYs 90-95		
Fiscal Year	**Amount Collected**	**# of Penalties Collected**
FY 90	$1,200	N/A
FY 91	$2,900	9
FY 92	$1,150	4
FY 93	$2,000	5
FY 94	$3,050	6
FY 95	$4,750	9
Total	$15,050	33(known)
Source of Data: Office of the State Treasurer, Second Injury Fund		

Another enforcement mechanism enacted as part of P.A. 95-277 is that before any building permit for a project worth $100,000 or more may be issued, the local building inspector must get proof of workers' compensation insurance coverage on all workers employed or hired to perform services at the construction site.

The additional tools enacted in the 1995 legislation have already increased enforcement activity. Since July 1, 1995, there have been 19 hearings held, and a total of $12,500 in fines have been imposed. Seven of those civil penalties have been paid, totaling $4,000.

Findings and Recommendations

The program review committee concluded that there are ample statutory mechanisms to enforce the insurance coverage requirements. The problem appears to be that historically the enforcement of these statutes has been weak. Public Act 95-277 removed some of the discretion commissioners have in holding hearings and in imposing civil penalties for insurance noncoverage. Since July 1, 1995, there has been an increase in enforcement activity.

While the recent legislation addressed the penalties and enforcement aspects, the law remains unclear about: who will collect the fines; which agencies will be notified, and when, that a civil penalty has been assessed; and when the Attorney General's Office will be notified that the civil penalty has not been collected. In discussions with the chairman of the WCC, the Office of the Attorney General, and the Office of the State Treasurer, it did not appear that any of them fully understood or carried out responsibilities in this area. Further, none of the three agencies keeps accurate track of the number of penalties assessed or the amounts imposed. The Second Injury Fund staff stated it had some records of penalties assessed that had come to its attention, but recognized it was not an all-inclusive list.

The program review committee believes the Workers' Compensation Commission should not be in charge of collecting penalties. The agency has not had clear responsibility for performing this function to date. For example, in the staff's case file review, a couple of files contained imposition of civil penalties, but it was unclear where the payment was to be made. One of the files also included notes that were in response to a letter from the Attorney General's Office concerning a civil penalty that indicated WCC staff were uncertain how to proceed. Further, the Workers' Compensation Commission seems ill-suited to follow up on any civil penalties that have been imposed. It does not have the staff to perform collection functions, and it is unlikely that following up on a penalty imposed will be a priority within the commission.

The committee believes it would be a more efficient and effective approach for the State Treasurer's Office to assume responsibility for the collection of penalties. That office has the accounting systems that can track collections, and the penalties can be placed in their system for issuance of demand letters, asset searches, and other appropriate collection steps. If collection efforts are unsuccessful in the 90-day period, the Office of the State Treasurer can notify the chairman of the Workers' Compensation Commission so that he can direct the Office of the Attorney General to proceed with civil action, if warranted. Further, since any penalty collections made are statutorily required to be deposited in the Second Injury Fund, it makes sense to cut out any unnecessary steps.

Thus, the Legislative Program Review and Investigations Committee makes the following recommendations:

> **Section 31-288(e) of the C.G.S. shall be amended to state that "Whenever a Workers' Compensation Commissioner imposes a civil penalty under Section 31-288(c) or (d), the order shall indicate that payment is to be made to the Second Injury Fund of the Office of the State Treasurer, and that failure to pay within 90 days may result in civil action and double the penalties. The chairman of the Workers' Compensation Commission shall notify both the Office of the State Treasurer and the Office of the Attorney General of the imposition of the penalty, the date it was imposed, the amount, and if such penalty is appealed. The state treasurer shall collect any penalties owed and shall notify the chairman of the Workers' Compensation Commission and the Office of the Attorney General if the penalty is not paid within the 90-day period so that civil action pursuant to Section 31-289 may be brought."**

The implementation of this recommendation will: streamline collection of penalties; provide notification of the proper agencies; clarify which agency actually does the collection; and place that responsibility in the most appropriate agency. The implementation should lead to a higher collection rate and more accurate accounting of civil penalties assessed for employer non-compliance.

In addition to the statutory changes that deal with the civil penalty assessment and collection processes, the program review committee concluded that a change should be made in the 1993 reform that would place a more stringent standard on employers who violate the workers' compensation

laws. Public Act 93-228 authorizes legal action against any employer who *wilfully and repeatedly* fails to comply with the statutes governing workers' compensation. The committee believes that this is a legal standard that is too easily violated without punishment and that the standard of violation should be knowledge of the violation or failure of compliance.

The committee also recognized that a similar standard was put in place last year as a result of the study of unemployment compensation where employers who *knowingly* employ someone off the books would be subject to a penalty. Therefore, the program review committee recommends that:

C.G. S. Section 31-289b be modified to state that the attorney general may bring civil action against any employer who KNOWINGLY fails to comply with any aspect of the workers' compensation statutes, and delete the current language of [willfully and repeatedly] fails to comply.

APPENDICES

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State of Connecticut

WORKERS' COMPENSATION COMMISSION

February 5, 1996

Mr. George McKee
Legislative Program Review and Investigations Committee
210 Capitol Avenue
Hartford, CT 06106

Re: **Workers' Compensation: Impact of Reform Legislation**

Dear Mr. McKee:

The Workers' Compensation Commission thanks the Program Review Committee for the opportunity to respond to the report titled: Workers' Compensation: Impact of Reform Legislation.

The Commission has given the report serious consideration and has analyzed each of the findings contained therein. We are pleased that most of these findings confirm that the Workers' Compensation Commission has successfully effected major improvements in the Workers' Compensation system in Connecticut. These improvements are the direct result of the Commission's conscientious and meticulous implementation of recommendations made directly by the Legislative Program Review and Investigations Committee in its 1991 report.

We disagree, however, with the substance or emphasis of some of the report's conclusions, based on careful analysis of data and the true significance of trends. This analysis is contained in the attached response to the report.

Sincerely,

Jesse M. Frankl
Chairman

JMF:nhc
Enclosure

INTRODUCTION

The Workers' Compensation Commission appreciates the hard work, effort, and thoughtful insights which are evident in the draft report titled: Workers' Compensation: Impact of the 1991 and 1993 Reform Legislation. The draft report contains much useful information, and the staff is to be commended for producing a work of such quality given the constraints of time, limited staffing, and the press of other obligations. The Commission, being daily immersed in the environment of workers' compensation issues, appreciates the opportunity afforded by the Program Review Committee to comment, elaborate, and expand on some portions of the draft report.

BUDGETED RESERVES

The first topic which we would like to discuss is that of the budgetary reserve. The historical reserve amounts of the past several years are criticized as being too high. Committee staff recommended that a cap of $5 million be instituted. The Commission believes that this is arbitrary. The reserve should equal real needs, whether it be $20.00 or $20 million. There are several reasons why the current reserve amount is appropriate. First, the assessment which funds the Commission is billed once a year, and cannot be depended upon to be received until the middle or end of the second quarter of the fiscal year. Thus, the Commission could face a potential shortfall of as much as $10 million. Also, the Commission has been authorized to pursue enhancements to its computer system, including an imaging system which could cost up to $6 million. If this portion of the automation project is not pursued, the money will be used to reduce assessments. Furthermore, the Commission has, in recent years, found itself with unanticipated expenditures imposed by the Legislature after the annual budget has been approved. These include adding of indirect charges in excess of $1 million and full funding of the Occupational Disease Clinics - approximately $600,000. It should be noted that the current reserve levels have met with the approval of the Workers' Compensation Commission Advisory Board and the Office of Policy and Management (O.P.M.)

APPENDIX A

Agency Response

O.P.M. has been critical of borrowing from the General Fund to finance the operations of the Commission - which could be necessary if the $5 million cap is approved.

MANAGEMENT POLICY

The second major area is the criticism of "micro-management" of the agency and the advocacy of backing away from the same. This recommendation seems to be based on a flawed survey of Commissioners and district office managers. It is natural for these parties to be resentful over what they correctly perceive to be diminished autonomy.

The Program Review Committee itself was the author of the micro-management strategy, a strategy which was further endorsed by the Legislature and which has shown great success in bringing uniformity to district office operations, expediting the hearing and dispute resolution processes, and making the employees of the agency more accountable and productive. What the staff refers to as "micro-management" has been the indispensable ingredient for the successful implementation of the administrative mandates of Public Act 91-339. Among these are the establishment of compensation districts and the assignment of staff, the separation of administrative and adjudicative functions, the establishment of consistent internal agency procedures, the development of standardized employment practices, the creation of staff development and training programs, and the creation of uniform procedures and forms to expedite case handling. Given this spectacular record of success, it makes no sense to turn back to the days of de-centralized fiefdoms, as noted by Committee Co-Chairwoman Eileen Daily, and Representative Curtis Andrews Jr. in their remarks on 12/21/95. We appreciate this show of support for the continuation of current administrative policies.

The Commission concurs with the recommendation that central management staff should spend more time at the district offices to foster better communication and understanding of roles and activities on the part of the respective parties. This is, to some extent, already being done by the Fiscal Administrative Manager, and will be expanded in the near future.

COSTS PER DISPOSITION

The report derives a rough measure of system efficiency by measuring inputs (expenditures) and system outcomes (hearings held and dispositions). The introductory paragraph states that "in global terms, the Commission has experienced a decline in efficiency." This conclusion is based on the results of "cost per disposition" and "cost per hearing" data which the Committees report indicates has changed over the two four-year periods by - 2.5% and + 5.7% respectively after adjusting for some funding differences.

A clearer comparison can be made by evaluating FY 89-91 as the pre-reform period and FY 93-95 as the post reform period. FY-92 has been omitted because many of the reforms were instituted mid-year. When addition obligations are accounted for in order to arrive at consistent expenditure figures, the Workers' Compensation Commission has clearly conducted hearings and arrived at dispositions more efficiently during the post-reform period than previously.[1] Per disposition costs decreased by 8.9% and the per hearing costs decreased by 18.1%.

pre-reform	**Cost per Hearing***	**Cost per Disposition***
AVERAGE	$261.29	$ 403.05
post-reform		
AVERAGE	$213.99	$ 366.99

**1988 constant dollars*

The Workers' Compensation Commission may have experienced even more significant efficiency gains vis-à-vis hearings due to the increasing number of formal hearings vs. informal hearings. The report correctly points out that there has been an increase in the litigousness of the system resulting in an increase in the necessity for formal hearings. These hearings require four to ten times the resources of an informal hearing, yet are counted for the purposes of this study as one and the same. When this additional information is incorporated into the findings, the evidence suggests that the Commission is becoming increasingly productive.

[1] Additional funding obligations during the post reform period include: State's Attorney Office, Criminal Justice Fraud Unit, $695 thousand; Indirect Overhead and Fringe under P.A. 91-14, $9.7 million ; One time costs for computer system, $4.6 million.

STAFFING

The Commission also wishes to comment on the recommendation that more staff resources be devoted to expediting caseload at the district office level. Without resorting to new hiring this would imply that resources be shifted from the Chairman's office to the district offices. This recommendation is not compatible with recommendations contained elsewhere. Specifically, the report recommends that the Commission begin to analyze the impact of medical reforms. This is a considerable order and is beyond the resources of the present staff who are too busy presently reviewing P.P.O. applications to take time out to begin meaningful data analysis. Since the very first P.P.O. was approved just twenty-eight months ago, 42 generic P.P.O.s covering nearly 200,000 employees have been approved. The staff is literally inundated with new and change requests which must be carefully reviewed prior to approval. Likewise, the report recommends that "[the Commission]...develop an oversight capability to monitor how insurers and/or employers are disseminating information about their managed care plans."

Finally, with regard to health and safety committees, it is recommended that the Commission's current monitoring efforts be modified to concentrate on companies with worse than average safety records. This once again implies a level of sophistication that would require more, not fewer employees at the Chairman's office.

COMPENSATION REVIEW BOARD

The report points out that the time required for the Compensation Review Board to issue a report has increased to 20 months. A recent review of the Compensation Review Board's records indicates that the actual time required to issue a report is approximately 17 months as recorded over the last 12 months.

The report states that " despite a 200% increase in staff... the board is unable to meet its statutory requirements." What this does not explain however, is that over 50% of the increases in staffing have occurred during the past twelve months. It should be noted that a normal learning curve can result in diminished initial productivity for new staff members. The board continues to reduce the backlog of cases and is working toward compliance with legislation. Given current productivity gains and the increased scheduling of Compensation Review Board hearings[2], it is anticipated that the Compensation Review Board will reach the 12 month goal in the near future.

(days)	HEARING TO OPINION	FINDING TO HEARING	FINDING TO OPINION
AVERAGE	196	323	519
HIGHEST	444	725	808
LOWEST	20	99	237

PHYSICAL AND ORGANIZATIONAL IMPROVEMENTS

During the past fiscal year the Chairman's offices were relocated from a strip mall location to offices located in the Capitol district of Hartford. Old deteriorated offices have been replaced by new, safe and clean facilities. While this move temporarily caused some disruption in services, it has resulted in increased morale and productivity among staff and allowed for better organization within the Commission.

Education and rehabilitation services have been enhanced while the cost of delivery for these services has been trimmed by eliminating directorial positions. Personnel, budgeting, purchasing, and business functions have been consolidated into single, rational units of control located within the Chairman's' office.

[2] The Compensation Review Board now meets approximately 24 times a year, compared with 10 times per year during the "pre-reform " era.

"WORKERS COMPENSATION: IMPACT OF THE 1991 AND 1993 REFORM LEGISLATION" A REVIEW OF OBJECTIVES MET.

The 1993 and 1995 Workers' Compensation reform legislation fundamentally transformed the workings of the Commission to the benefit of workers and employers throughout the State. This remarkable accomplishment was achieved only with the aid and input of legislators, business and labor leaders, as well as steadfast support on the part of the Governors and Attorney Generals' offices. We feel confident that the mediation process which injured workers and their employers enter into has been made more efficient and responsive to the needs and concerns of all involved. We would like to take this opportunity to review the successful execution of all parts of the agenda which was set before the Commission three years ago and acknowledge the contribution and assistance of all those who made this transformation possible.

⇒ Districts have been redrawn in order to better serve the public and are now evaluated on an on-going basis.

⇒ Internal Rules and Procedures have been established for the orderly execution of the internal business of the Commission.

⇒ An Annual Operations Plan and Budget are now formulated for review and serve as a fundamental tool for planning the future direction of the Commission.

⇒ Human and Physical Resources are centrally allocated in response to the changing needs of the district offices and all Administrative Affairs have been centralized within the Chairman's office

⇒ A uniform organizational structure has been established within the Commission.

⇒ Advisory Panels have been appointed to provide additional guidance to the Commission.

⇒ Practitioner Standards and Fee Schedules have been codified and instituted.

⇒ A formal process for the approval of Managed Medical Care Plans is now in place.

⇒ The Commissioners Hearing Schedule is determined and revised as needed to expedite caseload by the Chairman.

⇒ All Administrative Affairs have been centralized within the Chairman's office.

⇒ Case Processing and Records Maintenance are performed in accordance with promulgated standards.

APPENDIX B

SURVEY OF
WORKERS' COMPENSATION COMMISSIONERS AND FAOs

Number responding
- 12 commissioners
- 8 district administrators

Check which of the following applies to the date when you were first employed by the Workers' Compensation Commission
- 7 prior to January 1, 1992
- 3 between January 1, 1992 and June 30, 1993
- 8 on or after July 1, 1993

1. In general, how would you characterize the impact of the ***1991*** workers' compensation reform legislation on each of the following? (Please circle the number corresponding to your choice)

	Very Positive	Positive	Negative	Very Negative	No Opinion
Administration of System	3	12	2	0	3
Workers	4	2	11	0	3
Employers	1	15	1	0	3
Claimants' Attorneys	1	6	10	0	3
Employers' Attorneys	0	17	0	0	3
Insurers	4	12	0	0	4
Medical providers	1	9	4	0	6

2. In general, how would you characterize the impact of the ***1993*** workers' compensation reform legislation on each of the following? (Please circle the number corresponding to your choice)

	Very Positive	Positive	Negative	Very Negative	No Opinion
Administration of System	4	8	4	0	4
Workers	0	1	11	7	1
Employers	3	15	0	0	2
Claimants' Attorneys	0	1	13	5	1
Employers' Attorneys	1	14	3	0	1
Insurers	9	10	0	0	1
Medical providers	1	9	9	0	3

3. In general, how would you characterize your relationship with the following central office units? (Please circle the number corresponding to your choice)

	Excellent	Good	Fair	Poor	Not Applicable
Chairman's office	9	5	4	2	0
CAO's. office	3	2	4	5	3
Dist. Coordinator's Office	5	2	3	7	3
Business office	5	5	7	1	2
Personnel office	4	8	3	5	0
Manage. Information Sys.	3	3	4	6	4
CRB	11	7	2	0	0
Statistical	2	8	3	5	2

4. In general, are you satisfied with the support provided to you or your office by each of the following central office units? (Please circle the number corresponding to your choice)

	Very Satisfied	Satisfied	Dissatisfied	Very Dissatisfied	Not Applicable
Chairman's office	10	4	5	1	0
CAO's. office	1	5	6	4	4
Dist. Coordinator's Office	5	3	3	6	3
Business office	1	12	4	2	1
Personnel office	3	9	4	4	0
Manage. Information Sys.	2	5	7	2	4
CRB	10	10	0	0	0
Statistical	2	8	2	5	3

5. In general, how would you characterize the knowledge each of the following central office units have about the work you or your office performs? (Please circle the number corresponding to your choice)

	Very Knowledgeable	Know-ledgeable	Little knowledge	Very little knowledge	No Opinion
Chairman's office	10	4	6	0	0
CAO's. office	2	3	6	7	2
Dist. Coordinator's Office	4	0	6	6	4
Business office	1	4	8	5	2
Personnel office	2	3	8	6	1

Manage. Information Sys.	1	5	6	5	3
CRB	10	5	5	0	0
Statistical	1	5	5	6	3

6. In general, are you satisfied with the responsiveness of each of the following central office units to issues that you bring to their attention? (Please circle the number corresponding to your choice)

	Very Satisfied	Satisfied	Dissatisfied	Very Dissatisfied	Not Applicable
Chairman's office	10	5	3	2	0
CAO's. office	1	4	4	5	6
Dist. Coordinator's Office	4	3	3	7	3
Business office	1	13	3	2	1
Personnel office	5	7	5	3	0
Manage. Information Sys.	1	7	5	3	4
CRB	8	10	0	1	1
Statistical	2	7	2	4	3

7. Please include any comments you wish to make concerning the operation of the commission or the impact of the 1991 and 1993 legislative reforms.

APPENDIX C

Survey to Employers on Workers' Compensation

1. Prior to reading the cover letter attached, were you aware that the Connecticut General Assembly passed legislation to reform workers' compensation in 1991 and 1993?

   40 YES **11** NO

2. Overall, how would you characterize the impact the workers' compensation reform legislation has had on your business?

   3 Very Positive **22** Positive **5** Negative **0** Very Negative **23** Don't Know

3. Check all of the following items that you see resulting since the enactment of the legislative reforms:

on your business:

Yes	*No*	
14	**38**	We have fewer workers' compensation claims than we used to
29	**23**	Our workplace safety efforts have increased
7	**45**	Our medical claims costs are lower (if yes, what % lower than 1990 _____%)
10	**42**	Our costs for wage loss claims are lower (if yes, what % lower than 1990___%)

on the system in general:

Yes	*No*	
22	**24**	It's made the compensation benefits for claimants more reasonable
14	**37**	It's restricted the types of claims that are compensable
16	**35**	It's harder for workers to stay out for long periods
9	**43**	It's easier to get a hearing at the Workers' Compensation Commission

on the system in general:

Yes	*No*	
2	**50**	It's harder for workers to collect benefits
9	**43**	There's less fraud in the system now than there used to be
6	**46**	The changes have influenced the Workers Compensation Commissioners to rule more in favor of employers

Other (please specify) _____

5. Has your business adopted a managed care plan for your workers' compensation medical treatment?

15 YES **27** NO **2** SUBMITTED, NOT YET APPROVED

6. If yes, were you satisfied with the process for obtaining approval for the plan?

12 YES **1** NO, if no what were the problems _____

7. If you've implemented the plan, have you noticed a difference in your medical claims for workers' compensation?

3 YES **7** NO **7** TOO SOON TO TELL

7a. If yes, in what way have the claims changed? _____

8. Do you have a Health and Safety Committee established at your workplace?

27 YES **17** NO **4** ESTABLISHING ONE NOW

8a. If you have a committee, how long has it been since it was established? _____ Years

8b. In your opinion, has it lessened the number of injuries at your workplace?

19 YES **11** NO

9. What were you charged for the Second Injury Fund assessment in:
   1990 **$17,308** *1994* **$20,772** *1995* (to date) **$27,042**

10. Excluding the Second Injury Fund assessment, what were your workers' compensation premiums in: *1990* **$220,840** *1994* **$177,270** *1995* (to date) **$127,140**

11. If your premiums are lower now, to what do you attribute the decrease?

Yes	*No*	
9	**43**	Less payroll than in 1990
14	**38**	The reform legislation brought down rates
17	**35**	Our workers' compensation claims experience improved and decreased our premiums
2	**50**	We've increased the deductibles on our insurance policies
0	**52**	We've totally self-insured since 1990
10	**42**	The workers' compensation insurance market has become very competitive, lowering premiums for businesses
5	**47**	Other reasons (please specify) _____

12. Have you had a change in rating classification since 1993?

13 YES **22** NO **9** DON'T KNOW

12a. If your classification was changed, were you placed in a higher- or lower-rated classification?

7 HIGHER **6** LOWER

12b. Did you appeal your reclassification? **1** YES **14** NO

12c. After your appeal, were you still reclassified? **0** YES **3** NO

13. Have the workers' compensation reforms had any of the following impacts on jobs at your business? (Check all that apply)

Yes	*No*	
1	**51**	We would have had to cut jobs if the reforms had not been enacted
3	**49**	We still had to cut jobs, but fewer were cut as a result of the reforms
12	**40**	We cut about the same number of jobs as we would have without the reforms
6	**48**	We've been able to add jobs, and workers'compensation reform was partly responsible
8	**44**	We've been able to add jobs, but there is no connection with workers' compensation reform

14. Do you think that the reform legislation has had a negative impact on workers?

2 YES **37** NO

14a. If yes, in what way? _____

15. In terms of fairness to business interests, how would you characterize the decision-making of the Workers' Compensation Commissioners:

A) ***Prior to the legislative reforms***

0 Very Fair **7** Fair **10** Unfair **14** Very Unfair **12** No opinion

B) ***After the implementation of the legislative reforms***

1 Very Fair **14** Fair **9** Unfair **3** Very Unfair **16** No opinion

APPENDIX D

Survey of Employee Representatives on Workers' Compensation Reforms

1. Which of the following best describes the type of work your local members do?

   9 Construction **28** Manufacturing **3** Office/Clerical

   1 Health Care **1** Retail **30** Other (please specify mostly government)

2. Since 1990, approximately **how many** of your members have filed workers' compensation claims:
   before July 1, 1993: **1,194** *after July 1, 1993:* **942**

3. Prior to reading the cover letter attached, were you aware that the Connecticut General Assembly passed legislation to reform workers' compensation in 1991 and 1993?

   55 YES **6** NO

4. Overall, how would you characterize the impact the workers' compensation reform legislation has had on employees you represent?

   0 Very Positive **2** Positive **17** Negative **34** Very Negative **7** Don't Know

5. In general, can you explain why you think it has had this type of impact?

   _____

6. Since 1993, do you think the number of workers' compensation claims by workers you represent have:

   13 increased **10** decreased **36** stayed about the same

7. Prior to 1993, do you think the workers' compensation was abused by ***(% responding yes)***

   N = 61

41%	employers	**64%**	insurance companies
46%	lawyers	**16%**	workers
49%	doctors	**3%**	others (please say who)

8. If you checked any of the above, please say how you think there was abuse?

   _____

9. Do you think the 1991 or 1993 reforms have corrected any of those abuses:

1991: **4** YES **43** NO *1993*: **7** YES **42** NO

9a. If you said YES for either reform, please say how you think the reforms have corrected the abuses:

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10. How would you describe the following aspects of the workers' compensation system **before** the 1991 and 1993 reforms:

Filing a claim for workers' compensation was:

3 Too easy **34** Easy **13** Difficult **3** Too difficult

The benefits the average worker received while on workers compensation were:

18 Too low **1** Too high **35** About right

Workers usually stayed out of work:

5 Too many days **11** Too few days **39** About the Right Amount

Legitimate claims for compensation were:

21 Denied too often **34** Generally approved

Payment for claims:

43 Took too long **12** Were paid promptly

Time required to get a hearing before a commissioner on disputed claims:

34 Took too long **29** Was granted in a reasonable amount of time

11. Please say if you think the reforms have made these aspects better or worse:

The system for filing claims: **11** better **16** worse **27** same

Benefits Received: **2** more fair **45** less fair **8** about the same

Time workers are out on compensation: **6** better **10** worse **37** same

Acceptance of legitimate claims: **3** better **25** worse **27** same

Time for payment of claims: **1** better **21** worse **32** same

Getting a hearing before the commission: **13** harder **12** easier **28** same

12. Are any of your members now covered by an approved managed care plan for workers' compensation medical treatment?

24 YES **20** NO **13** NOT SURE

13. If yes, are those workers generally satisfied with the medical treatment provided by the plan?

5 YES **18** NO, if no what are the problems _____

_____

14. Have Health and Safety Committees been established at workplaces where your members are employed?

32 YES **13** NO **3** ESTABLISHING NOW

6 MOST OF THE PEOPLE I REPRESENT WORK FOR SMALL EMPLOYERS THAT AREN'T REQUIRED TO ESTABLISH COMMITTEES

14a. Are your members generally in favor of Health and Safety Committees?

56 YES **0** NO

14b. In your opinion, do Health and Safety Committees lessen the number of injuries at the workplace?

44 YES **9** NO

15. In your opinion, have the workers' compensation reforms had any of the following impacts on jobs where your members work? (Check all that apply)

Yes	*No*	
2	**56**	Jobs probably would have been cut if the reforms had not been enacted
3	**55**	We've still had job cuts, but probably fewer were cut as a result of the reforms
37	**21**	About the same number of jobs as we would have without the reforms
1	**57**	Jobs were added, and workers'compensation reform was partly responsible
10	**48**	Jobs were added, but there is no connection with workers' compensation reform
1	**57**	There are about the same number of jobs, but wages have increased because of the reforms

16. Do you think that the reform legislation has had a negative economic impact on workers?

22 Yes, I **know** injured workers who have had houses foreclosed on, or cars or other property repossessed

7 Yes, I've **heard of** injured workers who have had houses foreclosed on, or cars or other property repossessed

11 No, I don't know of any negative economic impacts on injured workers as a result of the reforms

17. In terms of fairness to workers' interests, how would you characterize the decision-making of the Workers' Compensation Commissioners:

Prior to the legislative reforms

8 Very Fair **34** Fair **7** Unfair **3** Very Unfair **4** No opinion

After the implementation of the legislative reforms

4 Very Fair **26** Fair **10** Unfair **9** Very Unfair **6** No opinion

Please feel free to add any comments about the reform legislation, its impact on workers' compensation, or the workers' compensation system in general. (Add another sheet if you wish)